Program Evaluation Division
Policy and Consultation Branch

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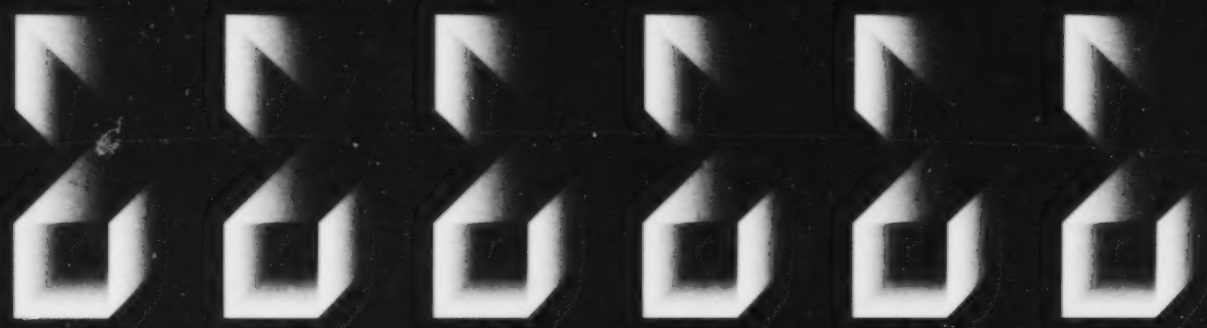

MID-TERM REVIEW OF HEALTH CANADA'S CONTRIBUTION TO CANADA'S DRUG STRATEGY

EXECUTIVE SUMMARY AND RECOMMENDATIONS

JUNE, 1995

Canada

MISSION STATEMENT

The Program Evaluation Division helps Health Canada serve Canadians better by providing objective information and advice about the effectiveness of departmental activities and services.

ÉNONCÉ DE MISSION

La Division de l'évaluation des programmes aide Santé Canada à mieux servir les Canadiens et les Canadiennes en offrant une information et des conseils objectifs sur l'efficacité des activités et des services du Ministère.

104-00976/

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executive summary and recommendations

CANADA'S DRUG STRATEGY

Canada's Drug Strategy is a five year sunsetting initiative involving seven federal departments intended to improve the effectiveness of Canada's drug programming. A predecessor initiative, the National Drug Strategy, began in 1987 and expired in March, 1992. Canada's Drug Strategy, Phase II, is a renewal and modification of the original National Drug Strategy, and it runs from 1992 - 1997. The federal Departments participating in the Strategy are Health Canada, Solicitor General Canada (which includes the Royal Canadian Mounted Police and Correctional Service Canada), Revenue Canada, Customs and Excise, Human Resources Development Canada, Department of Foreign Affairs and International Trade, Justice Canada, and Canadian Heritage.

This mid-term review of Health Canada's contributions to Phase II of Canada's Drug Strategy is intended to serve two purposes: to meet the Treasury Board requirement as described in its 1992 decision to allocate funds to Health Canada for the Drug Strategy, and to provide information to Health Canada that at a mid-point in Phase II will either confirm its current design and delivery or indicate the need for changes and recommend ways to bring them about.

Canada's Drug Strategy is an experiment in federal programming designed to make Canada's alcohol and drug interventions more effective at reducing the harm to individuals, families, and communities caused by problem alcohol and other drug use. It intends to make harm reduction activities more effective by enhancing existing programming, not by introducing altogether new programs. And programming will be enhanced primarily in four ways: by improving targeting, co-ordination, information, and resources. As agreed by the Treasury Board and by the Steering Committee for the evaluation of Canada's Drug Strategy, this report discusses only these four enhancements. Thus, the issues of the mid-term review are essentially about process, but processes that are critical to improved effectiveness. It is not itself concerned with the effectiveness of the component programs but rather with the value added by incorporating them into this inter-departmental initiative. Because data for measuring effectiveness will not be available until the final evaluation is

conducted, it will be only this larger study that attempts to determine the degree of effectiveness with which Canada's Drug Strategy has met its objectives.

HEALTH CANADA'S DUAL ROLE IN CANADA'S DRUG STRATEGY

Health Canada plays two roles in Canada's Drug Strategy. Not only does it deliver alcohol and other drugs programs, but it is designated as the lead department in the Strategy. That Health Canada is the lead Ministry has a symbolic importance in that it confirms the depiction of substance abuse as a health issue. But being the lead also involves responsibility for drafting the Memorandum to Cabinet, for housing the Canada's Drug Strategy Secretariat, for having an arm's length responsibility for the Canadian Centre on Substance Abuse, for co-ordinating the evaluation, and conducting the various activities that each of these implies.

Maintaining the lead in more than name means being able to retain the policy lead, which first and foremost means preserving the conceptualization of substance abuse as a health issue and preserving health goals as primary for Canada's Drug Strategy. Phase II witnessed a modest weakening of demand reduction funding that corresponded to a strengthened funding for law enforcement, particularly for the new Integrated Anti-Drug Profiteering Units. As deficit control becomes a more important determinant of government program design, one can predict increasing pressure on demand reduction programs whose effects are not expected to be immediate, unlike the anti-drug profiteering programs which can show, even if nothing else, at least an ability to reap profits in the short term. If the Strategy were to evolve so that law enforcement became the mainstay, Health Canada's lead would be jeopardized.

The Secretariat

Of considerable importance for Health Canada's day to day lead role in the Strategy is the Canada's Drug Strategy Secretariat. The Memorandum to Cabinet gave to the Secretariat a fourfold mandate for communications, co-ordination, data collection, and evaluation. This summary and the report discuss the Secretariat's performance in these regards only in so far as it concerns Health Canada's programming contributions to Canada's Drug Strategy. The inter-departmental report, which is on the overall Drug Strategy, discusses the Secretariat's activities beyond Health Canada's borders.

PROGRAM TARGETS

One of the ways that Canada's Drug Strategy, Phase II intended to become more cost-effective was by directing its programs to more

selective targets. The design presented in the Memorandum to Cabinet was to redirect some programming from the general population to sub-populations at high risk of drug-related harm. For a Strategy whose main objective is to reduce harm, this should be a more cost-effective approach than one that "targets" everyone in the hope of also capturing those at high risk or that tries to prevent low-risk sub-populations from becoming high-risk. In the parlance of the drug field, this is to favour secondary prevention over primary prevention. This shift in targets is important, and, to a degree, controversial. The approach of selecting high-risk populations, that is, those who already use or abuse alcohol and other drugs, is rejected by some who continue to believe that it is more effective to prevent non-users from becoming users. Among the proponents of primary prevention are some special interest groups and a few provinces and territories who maintain a policy of promoting abstinence over harm reduction. It must be stressed, however, that the decision to target the Drug Strategy in this way was made in consultation with the provinces and territories and met with the full support of most of them.

This targeting decision is consistent with the broad harm reduction approach that Canada's Drug Strategy, Phase II, takes to substance abuse in Canada. While Canada's harm reduction approach does not condone substance abuse, it does acknowledge it as a fact of our society and maintains that it is unrealistic to expect abstinence programming to succeed (except for children) in an environment characterized by substance abuse problems. It remains for the final evaluation of Canada's Drug Strategy to attempt to assess the effectiveness of this change in target.

Branch action

It is only in the Health Programs and Services Branch that Health Canada programs have brought about major changes to their program targets. This Branch has selected five high risk populations: children, youth, and young adults, particularly out-of-the-mainstream youth (dropouts, homeless, street youth); women, especially those who misuse prescription drugs and/or alcohol or who use alcohol or other drugs during pregnancy; seniors who mis-use prescription drugs or who combine drugs and alcohol; off-reserve aboriginals; and those convicted of driving while impaired. Each identified group has been addressed by the Branch, though in various degrees of intensity, depending on the specific program.

The Medical Services Branch was already working with one of these groups and the work of the Health Protection Branch in supporting

law enforcement is largely immune to change from these particular targets. However, these two Branches ought to consider the potential benefits of more selective targeting in their programs. These possibilities appear not to have been countenanced by these Branches in designing their Phase II programs. The next few years will be years of tight budgets. One can expect that selective targeting will remain an important vehicle for making most effective use of scarce resources.

Population Health Strategies

Health Canada has recently established a Population Health Strategies Business Line, one of four business lines presented in its first Business Plan, submitted to the Treasury Board in 1995. This business line represents a potentially influential policy change for the department, especially when coupled with the current determinants of health framework for explaining the health status of populations. The implications of this new attention to the health of populations and the underlying determinants of their health status have yet to be articulated in detail. Consequently, they have yet to be determined for Health Canada's role in Canada's Drug Strategy.

Despite this, it can safely be said that articulating these policies should involve program targets. A strong shift towards population health against a background of an account of the underlying determinants of health could mean giving more attention to affected populations than to health problems. Therefore, rather than focusing on specific health problems such as addictions, family violence, nutritional deficiencies, or AIDS, the focus could move to sub-populations related because they share a set of health determinants that gives rise to a multiplicity of health problems. As things stand now, it is common for different programs to have the same target populations. Who should be responsible for articulating the implications of these policy changes for substance abuse programs at Health Canada is the question.

RECOMMENDATION

The Canada's Drug Strategy Secretariat should take the lead and work with officials in the Population Health Strategies business line to explicate in detail the implications for substance abuse programming of the Health Canada Business Plan and its establishment of a population health strategies business line that is guided by the current understanding of the major determinants of health. This project should take special pains to describe the implications for program targets.

This project would necessarily involve research in the population health and determinants of health fields, including consultations with experts. One option for carrying out this project would be for the Canada's Drug Strategy Secretariat to let a contract for the work.

CO-ORDINATION

An assumption underlying the evaluation work already done and that is yet to be done is that co-ordination is definitive of Canada's Drug Strategy. Co-ordination is what will make a set of autonomous alcohol and other drugs programs a single strategy; without co-ordination, one can have a strategy only in name. It is co-ordination that makes strategies, and it is its performance in especially this area that will determine the success of this experiment in inter-departmental programming.

Goals Unclear

Although co-ordination was to be a crucial element of Phase I of the Drug Strategy, it was judged weak and was to be strengthened in Phase II. It was for this reason that the government created the Canada's Drug Strategy Secretariat. Although the Memorandum to Cabinet emphasized that the Strategy is to be co-ordinated and gave to the Secretariat the mandate for co-ordination, it contained no explicit or detailed co-ordination goals, and no goals have been developed and agreed upon by Strategy officials since. This lack of goals has affected the Strategy overall and Health Canada's components. At the outset of Phase II, it was unknown to Health Canada officials what co-ordination activities or outcomes were expected. This situation remains to this day.

Equally serious is the absence of clarity over the Drug Strategy Secretariat's roles and responsibilities for co-ordination within Health Canada and amongst the other federal partners. Their co-ordination role has been only partially accepted within Health Canada, and in so far as it is accepted, it appears limited to broad policy co-ordination; their contributions to program-level co-ordination seem not to be welcome.

The provinces

The provinces are extremely important to Canada's alcohol and other drugs programs. With the dissolution of the Federal-Provincial Advisory Committee on Alcohol and Other Drug Problems, the main mechanism for co-ordination on these issues between governments was lost. It has not since been replaced by another mechanism. During interviews, 100% of the provinces and territories maintained that co-ordination had become worse since the beginning of Phase II. At the

time that this summary was written it was unclear where responsibility lies for federal-provincial co-ordination on drug policy and drug programming. Co-ordination has become more difficult but at the same time more important with the actions taken by many provinces to decentralize health care including substance abuse services.

Location of CDSS

A question that arises in the context of the Secretariat's ability to co-ordinate is that of its location. One can ask whether the central co-ordinating function of a multi-departmental initiative ought to be within one of the participating departments at all. It has been general practice, in the federal government, to place co-ordinating bodies of multi-departmental initiatives within the line department designated as the lead. The National Strategy for the Integration of Persons with Disabilities, for example, is co-ordinated out of Human Resources Development Canada. In this case, Health Canada has been designated as the lead, and it therefore seems most appropriate that the Drug Strategy Secretariat be located in that department. The fact that Health Canada has programs in both supply and demand reduction reinforces its suitability.

The question of location also arises within Health Canada itself. There are three line branches in the department that deliver autonomous Drug Strategy programs in both the supply and demand reduction sectors. Originally, the Secretariat reported directly to the Deputy Minister, then to the Associate Deputy Minister (1992), then to the Assistant Deputy Minister of the Policy and Consultation Branch (1993); in these reporting relationships, the Secretariat was independent of the line branches delivering Drug Strategy programs. In 1994 it moved to the Health Programs and Services Branch, reporting to the Assistant Deputy Minister, and now it reports to a Director General within that same Branch. This was a very recent move and it is too early to discern what effects it will have on the Secretariat's co-ordinating abilities.

The mid-term review did, however, indicate a perception within the Secretariat that its position as Strategy co-ordinator has been weakened by their being placed within one of the line Branches of Health Canada, a Branch that has a heavy responsibility for programs in the demand reduction area of Canada's Drug Strategy. This, they believe, makes it more difficult for the Canada's Drug Strategy Secretariat to convince other players within Health Canada and elsewhere in the federal government that they act on behalf of the entire Strategy. It is difficult to convince other departments to regard it as representing

them and not just Health Canada, and it remains difficult for them to convince Health Canada that it represents them, too.

To what extent these organizational changes have affected the abilities of the Secretariat to co-ordinate amongst the federal departments is somewhat unclear. The mid-term review did not explicitly consider this particular issue. However, it would appear to be of sufficient significance to study in its own right during the final evaluation, when the effects of these changes will be more fully evident.

A confusion, notable for its persistence, is over the roles of the Secretariat and the Canadian Centre on Substance Abuse. For years, a certain degree of mystery has existed regarding the respective roles of these two organizations despite attempts by both organizations to clarify their mandates and the differences between them. The report of the 1993 evaluation of the Canadian Centre on Substance Abuse also discussed this situation (pp. 53-57). These problems can only weaken the ability of the Secretariat to act as a co-ordinator and can only weaken the benefits that were supposed to accrue to Canadians from co-ordinating the drug-related activities of the seven participating departments. Should the name of the Canada's Drug Strategy Secretariat change as a result of the new Branch structure, this might further add to the confusion over its roles and responsibilities.

Co-ordinating Activity

The Canada's Drug Strategy Secretariat has engaged in co-ordinating work within Health Canada. (Again, the inter-departmental report covers their work between departments.) Some examples are:

- organizing conferences and workshops on the issue of how to deal most effectively with out-of-the-mainstream youth;
- developing in concert with representatives of drug programming and related programming (such as concerns AIDS and family violence) a position paper on harm reduction for Health Canada;
- working with Branch representatives on policy issues of relevance to Bill C-7, which is to replace the Narcotic Control Act and Parts III and IV of the Food and Drugs Act.

There is a considerable amount of co-ordination within the Health Programs and Services Branch, much of it the result of the work of the Alcohol and Other Drugs Programs Unit. The bulk of their responsibility is within this Branch, but they have worked conjointly with the Medical Services Branch on program design for off-reserve

aboriginal peoples. The Health Protection Branch has been less involved in co-ordinating its work with the other branches or with the Secretariat. This has been particularly evident in the drafting of Bill C-7; the Health Protection Branch has done little to involve the other branches in this work despite the implications for them, especially regarding policy.

RECOMMENDATIONS

In order to strengthen and foster co-ordination of Canada's Drug Strategy within Health Canada and to increase the effectiveness with which the Canada's Drug Strategy Secretariat carries out its co-ordination mandate,

1a. Even though the final evaluation will consider the effects of the Secretariat's location on its ability to foster co-ordination, Health Canada should in the meantime examine whether a program Directorate within a line Branch is the optimum location from which the Canada's Drug Strategy Secretariat can discharge its responsibilities to co-ordinate the Strategy within and outside the department.

1b. For as long as it remains in its current location, Health Canada should consider how the Secretariat can best work with all of the Department's line Branches and with the other federal partners in fulfilling its mandate for Canada's Drug Strategy. No matter what its organizational location the name of the Canada's Drug Strategy Secretariat should be retained;

2. The roles and responsibilities of the Secretariat with respect to Health Canada's Drug Strategy programs should be clarified and communicated amongst Strategy officials;

3. Specific goals for co-ordination within Health Canada and between Health Canada and other federal Drug Strategy partners should be established, communicated, and acted upon as soon as possible;

4. The responsibility for federal-provincial/territorial co-ordination on matters of substance abuse policy and programming should be clarified and communicated as soon as possible. Consideration should be given to creating

a body responsible for co-ordination between these levels of government, especially regarding demand reduction.

5. **The Canada's Drug Strategy Secretariat should continue and strengthen its efforts to identify opportunities for co-ordinating program activities and to communicate these opportunities to program officials.**

It is to be understood that the responsibility for co-ordination cannot rest solely with the Canada's Drug Strategy Secretariat. Responsibility must also be accepted by Strategy officials throughout the Department and by those organizations, such as the Steering Committee and the Inter-departmental Committee, established to facilitate co-ordination.

INFORMATION

Appeal to sound information is essential to policy development, program design, program targeting, and co-ordination. Sound information has always been essential to making rational decisions, but, now, its importance equally lies in providing services in the most cost-effective manner possible. Health Canada received funds from Canada's Drug Strategy explicitly for information purposes. The programs or organizations that received money specifically targeted for information were:

- Canada's Drug Strategy Secretariat
- National Health Research and Development Program
- Canada's Alcohol and Other Drugs Survey
- Canadian Centre on Substance Abuse

The work of the Secretariat has included a project to develop an alcohol and drug epidemiological data base, a project to develop a model for collecting data that indicate the economic costs of drug-related harms, and a project to co-ordinate drug-related research results in Canada and the United States. These projects are being carried out in conjunction with other organizations such as the Canadian Centre on Substance Abuse and the Alcohol and Other Drugs Programs Unit of the Health Programs and Services Branch.

No plan for information management

What appear to be missing are the links between the information needs of Health Canada, the data and/or information that is actually produced, and, finally, the use of this information for decision-making. To put the point yet more generally, what appears to be

missing is a plan that would integrate the production and use of information to the objectives of Canada's Drug Strategy.

This problem is not unique to Health Canada's Drug Strategy programs. The evaluation of the National Health Research and Development Program demonstrated the difficulties in disseminating and using research results; and the Health Canada business line reviews of 1993-1994 indicated shortcomings in the development and use of information in the department. Phase I of the Strategy did include a data needs assessment. A document was produced but apparently little used, partly because of the high cost of collecting the information it suggested. Phase II neither uses this old document nor has replaced it. Without a clear idea of what data are needed, for what purposes, and by whom, the department and the Drug Strategy risks making decisions on the basis of insufficient evidence, or of wasting money producing information that is not needed, that is not used because it is not properly disseminated or properly presented, or by duplicating effort.

There exist, however, examples of beneficial information exchange, despite the lack of a departmental information plan. The shared work concerning off-reserve aboriginals brought about a sensible sharing of information between the Branches designing programs for this population. And there are fora for information exchange: the interdepartmental committees that meet to exchange information, the Canadian Centre on Substance Abuse with its drug information clearinghouse, and the Canada's Drug Strategy Secretariat.

RECOMMENDATIONS

The 1995-98 Health Canada Business Plan emphasizes the role of information in decision-making through the strengthening of its health intelligence system and other sources of information to further evidence-based decisions. This general emphasis on evidence-based decision-making is shared with the National Forum on Health and current Treasury Board policy on review.

In keeping with this emphasis and with the need for the Department to participate in the decision-making surrounding the sunsetting of Canada's Drug Strategy, the Canada's Drug Strategy Secretariat should begin to work with Strategy officials at Health Canada and with the other federal partners on systematically determining the information needs of Canada's Drug Strategy, the

extent to which these needs are being fulfilled, and what actions need to be taken to bring improvements to the management of information in support of substance abuse programming and policy making at Health Canada.

RESOURCES

Canada's Drug Strategy is a sunsetting initiative. In these times of scarce resources, sunsetting initiatives have become a more popular way to fund programs. In theory, establishing sunsetting programs allows the government to respond to special problems without being committed to long-term expenditures. In the case of Canada's Drug Strategy, Phase I, the government was responding to a perceived unusual severity in alcohol and other drug-related problems in Canada. The Strategy was renewed for a second phase on the grounds that the problem persisted, that the balanced approach the Strategy represented was sound, and that it needed to be given a more focused set of targets for maximum effectiveness.

Strategy organizers must face the possibility, however, of non-renewal and plan for how it would deal with the loss of a substantial influx of funds. The loss of supplementary funds could bring about the collapse of the Strategy, especially the intended element of co-ordination. It is crucial to recognize that the Strategy is not entirely dependent upon additional funds, that through the other means of program enhancement, it could continue to exist even with a loss of the sunsetting dollars. Also, given that a large proportion of its funds is to supplement programs previously receiving A-base funds, were it to sunset would not automatically imply the cessation of the programs that fall under it. Most Health Canada programs are at least partially funded through ongoing funds; very few receive their entire budgets through the Drug Strategy. Those that do are in the Health Programs and Services Branch.

RECOMMENDATION

Health Canada should strive, even in the event that the resource supplements provided by Canada's Drug Strategy are not renewed, to ensure that the other mechanisms of program enhancement (targeting, information, and especially co-ordination) are maintained within Health Canada and amongst the federal partners, and that an organization be clearly designated with the responsibility to do so.

DRUG-RELATED HARM TO INDIVIDUALS

Canada's Drug Strategy was introduced in 1987 as a special measure to counter a perceived increase in the severity of substance abuse problems in Canada. The 1992 framework document described a range of harms that the Strategy was to attempt to reduce. One of these is premature death. Mortality data from the years 1987 to 1992, the most recent year for which Statistics Canada data are available, do not give reason for optimism and should be of concern to Canada's Drug Strategy officials. The following figures are presented primarily to highlight an important facet of the Strategy's environment, not as in themselves an indicator of the effectiveness of Canada's Drug Strategy or of Health Canada's role in it, but as portraying a situation in need of immediate attention from Drug Strategy officials.

DRUG OVERDOSE DEATHS IN CANADA, 1987-1992

Drug type	1987	1988	1989	1990	1991	1992
Opiates	56	55	58	82	133	148
Cocaine	59	80	99	65	92	78
Barbiturates	45	34	34	29	30	29
Alcohol	120	116	112	110	155	178
Tranquilizers	27	20	24	23	17	15

Although these Statistics Canada data indicate a slowly declining incidence of overdose deaths due to barbiturates and benzodiazepine-based tranquilizers, the trends for the opiates, of which heroin is the most common, cocaine, and alcohol give cause for concern. From the time that the Drug Strategy began in 1987 until 1992, heroin deaths have increased by 265%, cocaine deaths have increased by 32%, and deaths due to alcohol poisoning have increased by 48%. (Note that overdoses account for a small percentage of deaths attributable to alcohol abuse; consider, for example, cirrhoses of the liver, impaired driving, and acts of violence.) Whatever the cause of these trends, they show that Canada's Drug Strategy is not yet meeting its goal of reducing premature deaths caused by these drugs. Its general harm reduction approach should have application to whatever it is that is causing this disturbing trend in drug-related mortality.

Drug deaths in British Columbia

These data do not tell the worst of it because they do not go beyond 1992. However, the province of British Columbia has experienced a severe escalation of drug overdose deaths since 1992. The numbers from 1993 for British Columbia alone, depicted in the table below, are striking.

Drug Type	Deaths
Heroin	298
Cocaine	106
Alcohol	145
Total	549

This situation is clearly extraordinary and it might not be unreasonable to characterize it as a crisis because the number of overdose deaths far exceeds past patterns. At the time that this report was written, Canada's Drug Strategy had made no formal Strategy-wide response to the British Columbia situation. Canada's Drug Strategy regards the province of British Columbia as having sole jurisdiction over this situation, at least until the province indicates that federal involvement is appropriate. Accordingly, the Canada's Drug Strategy Secretariat is taking a position of waiting for a clear signal from the province of British Columbia before it reacts.

The Department has a history of becoming involved with the provinces in crisis situations. The Department has in recent years responded swiftly and effectively to threats posed by tainted mussels and imported grapes as well as to natural disasters such as the Edmonton tornado. One might be excused for expecting there to be an analogous capacity within the drug field where the severity of the harm can be very high.

However, there appears not to exist a plan for the federal government to respond to drug-related emergencies, either on its own or in concert with the provinces. Further, as noted earlier in this report, with the disbanding of the Federal-Provincial Advisory Committee on Alcohol

and Other Drug Problems, there no longer exists an organization with a clear responsibility for federal-provincial co-ordination on drug issues, including extraordinary or emergency situations. The situation in British Columbia poses a challenge to the Canada's Drug Strategy partnership, one piece of which is to be federal-provincial, to take joint action in extraordinary situations.

The British Columbia situation is one where a harm reduction approach to substance abuse should have something to offer. It must be noted, however, that Vancouver is not the only city with recently elevated overdose death levels. Toronto and Montreal have also experienced increases, albeit, not to the same extent. Without either a plan or an organizational capacity, it would appear that the federal-provincial partnership has work to do to define what a harm reduction approach to substance abuse involves and implies for federal government and joint federal-provincial action in extraordinary situations.

RECOMMENDATION

Health Canada Drug Strategy officials should work in concert with the Interdepartmental Steering Committee, the Canada's Drug Strategy Interdepartmental Committee, and representatives from provincial/territorial and municipal governments to develop a co-ordinated plan of action for responding to situations involving unusually high levels of drug-related harm such as this profusion of overdose deaths in a short period of time.

Health Canada Santé Canada

Program Evaluation Division
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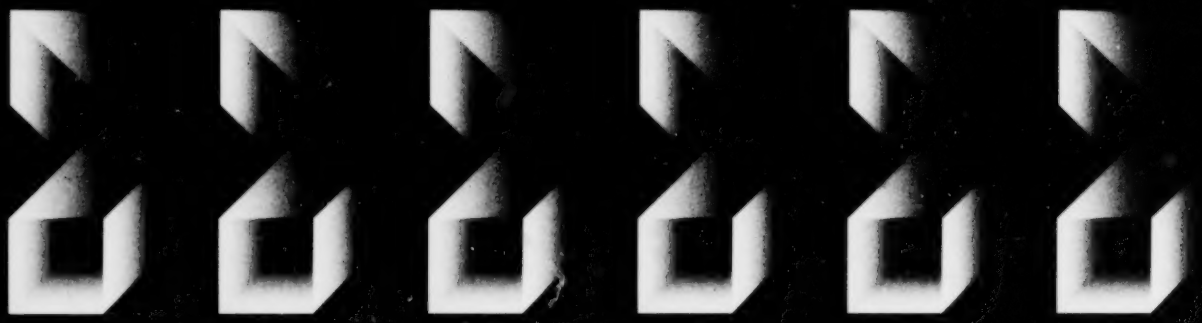

MID-TERM REVIEW REPORT

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JUNE, 1995

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MID-TERM REVIEW REPORT

HEALTH CANADA'S CONTRIBUTIONS TO CANADA'S DRUG STRATEGY

JUNE, 1995

Evaluation Group
Policy and Consultation Branch

evaluation chronology

June, 1993	Baseline data collection complete, discussion paper submitted to CDSS
June, 1994	Terms of Reference drafted for mid-term review
June, 1994	Data collection begins
November, 1994	Data submitted to Program Evaluation Division, Health Canada, by Educon Marketing and Research Systems
November, 1995	Final report approved by Audit and Evaluation Committee, Health Canada

credits

The Program Evaluation Division of Health Canada was responsible for carrying out this project. Howard Duncan was the project manager and wrote the report.

Educon Marketing and Research Systems conducted the focus groups and the majority of the interviews.

The Canada's Drug Strategy Secretariat provided advice and organizational support.

The Health Canada Program Working Group for Canada's Drug Strategy provided advice and logistical support.

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introduction

Canada's Drug Strategy is a five year sunsetting initiative involving seven federal departments and intended to improve the effectiveness of Canada's drug programming. A predecessor initiative, the National Drug Strategy, began in 1987 and expired in March, 1992. The term, Canada's Drug Strategy, here refers to a renewal and modification of the original National Drug Strategy. This renewal initiative is often called Phase II of Canada's Drug Strategy and it runs from 1992 - 1997. The federal Departments participating in the Strategy are:

- Health Canada
- Solicitor General Canada, which includes the Royal Canadian Mounted Police and Correctional Service Canada
- Revenue Canada, Customs and Excise
- Human Resources Development Canada
- Department of Foreign Affairs and International Trade
- Justice Canada
- Canadian Heritage

This report is of the mid-term review of Health Canada's contributions to Phase II of Canada's Drug Strategy. It is intended to serve two purposes, to meet the Treasury Board requirement as described in its 1992 decision to allocate funds to Health Canada for Canada's Drug Strategy, and to provide information to Health Canada that at a mid-point in Phase II will either confirm its current design and delivery or indicate the need for changes and ways to bring them about.

A BRIEF DESCRIPTION OF CANADA'S DRUG STRATEGY

Canada has been involved in drug programming for decades: our first drug legislation appeared in 1908, and there have been decades of effort waged by governments at all levels, by non-governmental organizations, and by citizen-led community groups to deal with the risks of alcohol and other drug use . Underlying the development of the Drug Strategy is the idea of taking fullest advantage of these efforts by assembling a single system from the separate programs and

enhancing selected areas. Canada's Drug Strategy is, then, intended to be a **comprehensive** inter-Departmental federal initiative to enhance and co-ordinate alcohol and drug programming in the three traditional program areas: prevention, treatment and rehabilitation, and law enforcement. It is something of an experiment in inter-departmental programming, and this mid-term review intends to provide information on how well the experiment is working.

The Strategy works through enhancements intended to, in general, increase the effectiveness of selected existing programming. It is to improve program targeting, strengthen co-ordination, and augment the information and resource bases. Cabinet created two co-ordinating organizations, the Canada's Drug Strategy Secretariat and the Canadian Centre on Substance Abuse. It is important to bear in mind that increased funding is only one of the vehicles for enhancing programs. In theory, Canada's Drug Strategy is to be far more than an injection of dollars; its success or failure will depend heavily on the degree to which its targeting, co-ordination, and information base are improved. Budget cuts, where they occur, can be expected to affect the performance of Canada's Drug Strategy, but they will not make or break it. Of at least equal importance are the other three ways of improving performance.

This broad design is common to both Phase I and Phase II. However, Phase II does differ in a number of ways from its predecessor:

- there have been a number of changes in target populations;
- more attention is being paid to enforcement and control, especially to implementing the Anti-Drug Profiteering legislation; and
- the Strategy Against Driving While Impaired is now part of Canada's Drug Strategy, whereas it was a separate initiative until 1992. Those convicted of impaired driving are now among the target groups for the Health Programs and Promotion Branch; there is no longer specially designated funding for programs for impaired drivers.

The Environment

Canada's Drug Strategy, Phase II differs from the original in response to perceived changes in the drug field. The environmental factors that were cited as having most contributed to design changes were that:

- Canada had become more of a transit way for illegal drug shipments;
- Proceeds of Crime legislation was in place and requires special resources for taking fullest advantage of it; and
- the provinces had become heavily involved in prevention programming for the mainstream population, making it possible for the federal government to concentrate on high-risk sub-populations.

Of these, targeting changes have had most impact on Health Canada. Phase II is intended to place more emphasis in prevention programming upon such high-risk or otherwise non-mainstream groups as street kids, dropouts, off-reserve aboriginals, the unemployed, seniors, women, impaired drivers, and dysfunctional families. This short list, taken from the Memorandum to Cabinet, is but a list of examples. It is to the judgement of the Departments participating in the Strategy's prevention programs which specific risk groups to target. The general conceptual shift, however, is from targeting the population in general, most of whom are not at risk of suffering from drug-related problems, to targeting specifically those who are at a high-risk of having problems. In the parlance of the drug field, this change marks a shift in emphasis from primary prevention to secondary prevention. (Treatment is sometimes called tertiary prevention.)

Broad Design

In general, however, Phase II of Canada's Drug Strategy is very similar to Phase I. Most of the changes are adjustments. In Phase II, the Strategy remains a comprehensive inter-Departmental federal initiative intended to enhance and co-ordinate alcohol and drug programming in prevention, treatment and rehabilitation, and enforcement and control. Importantly, Phase II continues to cast substance abuse as primarily a health problem, and, for this reason, has maintained Health Canada as the lead department. It is for this reason that demand reduction features so prominently in the design of Canada's Drug Strategy. In the decade prior to the introduction of the National Drug Strategy in 1987, the federal government was very little involved in demand reduction programs directed towards psychoactive drugs other than alcohol. The National Drug Strategy, from the point of view of program design, marked an important shift away from the federal government's almost total reliance upon law enforcement and supply control regulations to deal with the abuse of these drugs. It was characterized as taking a balanced approach towards an issue that had come to be seen as a health issue and not just as a matter of criminal

justice. By taking this approach, Canada was putting into practice what many international experts in the substance abuse field had been advocating for years and what was becoming an increasingly strong interest for the United Nations' organizations involved in drug control. It should be noted that Canada was among the leading advocates for demand reduction at the United Nations.

However, the financial supports that Phase II of Canada's Drug Strategy brings to existing programming have, at least in design, moved more towards enforcement and control. In Phase I, monies for demand reduction comprised 70% of the Strategy's intended outlay; in Phase II, according to the Memorandum to Cabinet, only 60% of the funding goes to demand reduction. It will remain for the final evaluation, due to the Treasury Board in January, 1997, to determine the significance of this change. Nonetheless, the mid-term review notes what appears to be a decrease in the emphasis upon demand reduction and asks whether it signals a shift in the federal government's thinking about the fundamentals of substance abuse programming, whether it suggests the beginnings of a return to that thinking wherein substance abuse is primarily to be seen as a crime issue to be dealt with by enforcement rather than a health issue to be dealt with in a balanced fashion, as the stated rationale of the National Drug Strategy maintained.

Funding

Cabinet approved the following funding to Health and Welfare Canada under the renewal of Canada's Drug Strategy:

Year	1992-93	1993-94	1994-95	1995-96	1996-97
$000s	35,270	39,770	39,770	38,270	38,270

Following the re-organization of government and the subsequent transfer of the Alcohol and Drug Treatment and Rehabilitation cost-shared program to Human Resources Development Canada and the transfer of the Anti-doping program to Canadian Heritage, the original allocations to Health Canada became those depicted on the table on the following page. If one takes into account the ongoing funding, Canada's Drug Strategy was to be a $270.0 million five year initiative.

Year	1992-93	1993-94	1994-95	1995-96	1996-97
$000s	19,370	23,870	23,870	22,370	22,370

LIMITS TO THIS STUDY

There are 14 initiatives at Health Canada funded by Canada's Drug Strategy. This mid-term review is not a review or program evaluation of each of these initiatives. Rather, it examines the way in which the changes to be brought to Health Canada by Canada's Drug Strategy have influenced alcohol and other drug programming in the Department. Proceeding in this way has meant making a conceptual distinction between Canada's Drug Strategy and the programs that fall under its name.

A conceptual distinction

The Evaluation Framework of December, 1992 characterized Canada's Drug Strategy as an experiment in federal programming designed to make Canada's alcohol and drug interventions more effective at reducing the harm to individuals, families, and communities caused by problem alcohol and other drug use. This is how the Memorandum to Cabinet states its main objective. It should be noted that framing the objective of the Drug Strategy in terms of harm reduction was new to Phase II. The framework further characterized the Strategy in terms of two "orders of objective" more specific than this broad objective. The other orders of objective are related to this basic objective as means to end. Accordingly, Canada's Drug Strategy intends to make harm reduction activities more effective by enhancing existing programming, not by introducing altogether new programs. (This point does not imply that the existing programs do not innovate.) And programming will be enhanced primarily in four ways: by improving targeting, co-ordination, information, and resources. Specifying Strategy objectives in three orders is intended to make its overall structure clearer.

The issues covered by this report include only the enhancements that Canada's Drug Strategy intends to bring to Health Canada's alcohol and drug programming. The pre-occupation of the review is with whether the Strategy adds significant value to the programming that it supplements. It is not concerned with the effectiveness of the existing programs but rather with the value added to them by incorporating them into an inter-departmental initiative. The final evaluation will attempt to determine the degree of effectiveness with which Canada's

Drug Strategy has met its objectives. Put in the form of questions, this mid-term review sought answers to:

Targeting:

- What changes in targeting were to be made in programming in this Department?
- What changes were actually made?
- On what basis were these changes made?
- What effects have they had?

Coordination:

- How were coordination and cooperation to be improved within the Department and between this Department and other federal departments and Drug Strategy partners?
- What actions were actually taken to make these improvements?
- Are there effective mechanisms for coordinating initiatives within this Department?
- How do Departmental officials perceive the role of the Canada's Drug Strategy Secretariat? Is the role of the Secretariat understood by Departmental officials?

Improved Information Base:

- What improvements to the information base did each component intend to bring about?
- What improvements did they actually bring about?
- How did those involved in Canada's Drug Strategy initiatives within the Department use this information and the information from other sources that benefited from Canada's Drug Strategy?

Resources:

- What increased resources was this Department to receive from Canada's Drug Strategy?
- What resources did it actually receive over the five years?
- How were the resources actually used? Were they used for Drug Strategy purposes as intended or for other purposes?

It was not expected that full answers would be available to each of these questions. Not enough time has passed for all of the Phase II changes to display their effects. However, the review was able to determine whether the above-listed actions of Phase II are underway, whether improvements in targeting have been made, whether a greater degree of co-ordination and co-operation has come about, whether developments in the information base are becoming evident, and whether programs have received their anticipated resources and are using them as Canada's Drug Strategy intended.

It is important to note that this review does not attempt to determine how effective Health Canada's contributions to Canada's Drug Strategy have been at reducing alcohol and drug-related harm. Again, effectiveness questions will be raised only in the final evaluation. The reason for this is quite straightforward: data for assessing the effects of the Strategy are not now available and will not be until the final evaluation is conducted. One pertinent example is that it was only in November, 1994 that Statistics Canada released mortality and morbidity statistics for 1992; this would cover only the first six months of Phase II of the Strategy.

Data sources

The information upon which this review is based was collected from three sources: program documents, interviews with representatives of Health Canada and with representatives of agencies of the provinces and territories responsible for addictions services, and focus groups with Health Canada officials.[1] (Endnotes begin on page 65 of this report.)

HEALTH CANADA'S DUAL ROLE IN CANADA'S DRUG STRATEGY

Health Canada plays two roles in Canada's Drug Strategy. Not only does it deliver alcohol and other drug programs, but it is designated as the lead Department in the Strategy. That Health Canada is the lead Ministry has a symbolic importance in that it confirms the depiction of substance abuse as a health issue. Being the lead also involves responsibility for drafting the Memorandum to Cabinet, for housing the Canada's Drug Strategy Secretariat, for having an arm's length responsibility for the Canadian Centre on Substance Abuse, for co-ordinating the evaluation, and conducting the various activities that each of these implies. However, maintaining the lead in more than name means being able to retain the policy lead, which first and foremost means preserving the conceptualization of substance abuse as a health issue and preserving health goals as primary for Canada's Drug Strategy. Again, the Memorandum to Cabinet indicates a slight shift in Phase II from demand reduction funding to law enforcement

funding, particularly for the new Integrated Anti-Drug Profiteering Units. As deficit control becomes a more important determinant of government program design, one can predict increasing pressure on demand reduction programs whose effects are not expected to be immediate, unlike the anti-drug profiteering programs which can show, even if nothing else, at least an ability to reap profits in the short term.

The Secretariat

Of most importance for Health Canada's day to day lead role in the Strategy is the Canada's Drug Strategy Secretariat. The Memorandum to Cabinet gave to the Secretariat a fourfold mandate for communications, co-ordination, data collection, and evaluation. This report discusses the Secretariat's performance in these regards only in so far as it concerns Health Canada's programming contributions to Canada's Drug Strategy. The inter-departmental report, which is on the overall Drug Strategy, discusses the Secretariat's activities beyond Health Canada's borders.

Programs

Again, Canada's Drug Strategy is intended to be a comprehensive initiative in that it encompasses the three traditional programming areas of prevention, treatment, and law enforcement. Prior to the 1993 re-organization of government, Health Canada was involved in all three areas, but with the transfer of the Alcohol and Drug Treatment and Rehabilitation Program to Human Resources Development Canada, it is now much less involved in addictions treatment and rehabilitation; only the Medical Services Branch works in this area. Currently, its programs are delivered by the Health Programs and Services Branch (which houses the Canada's Drug Strategy Secretariat and has some budgetary responsibility for the Canadian Centre on Substance Abuse), the Health Protection Branch, and the Medical Services Branch. The Policy and Consultation Branch is involved in policy development and evaluation. The programs and activities in each program Branch are as follows:

Health Programs and Services Branch

- Prevention Initiatives:
  - Program and Policy Development
  - Education and Training
  - Research and Knowledge Development
  - Community Action
  - Social Marketing

- National Health Research and Development Program Initiatives
- Canada's Drug Strategy Secretariat

Medical Services Branch

- Addictions and Community Funded Programs: On Reserve
- Addictions and Community Funded Programs: Off Reserve

Health Protection Branch

- Drug Abuse Among Health Professionals
- Drug Identification and Analysis
- Drug Diversion Prevention
- New Legislation
- Control of Precursors and Anabolic Steroids

Again, this report is not of a review of each of these programs. Rather, it examines the ways in which Health Canada's contributions to Canada's Drug Strategy have put in place the mechanisms for program enhancement: improved targeting, co-ordination, information, and resources. The report, then, is structured according to these topics.

chapter 2
program targets

BACKGROUND

The issue of program targets concerns the sorts of populations that the programs are directed towards. Canada's Drug Strategy is described as a targeted initiative. Rather than directing its program efforts to the entire Canadian population, it is to restrict its activities to those populations considered in most need of attention. The intention appears to be that targeting will pay off in greater cost-effectiveness because money will not be wasted through program efforts directed towards people, institutions, or conditions not requiring them.

There are a number of targeting issues that one could consider in the alcohol and other drugs field, among them:

- should programs target specific drugs or drug types?
- should there be equal or disparate attention paid to the three traditional programming areas of prevention, treatment, and enforcement?
- should programs pay special attention to specific sub-populations or direct its activities towards all Canadians?

This report will consider only the last of these; the other questions are discussed in the report concerning the Drug Strategy overall.

Health Canada's intentions

The Memorandum to Cabinet did not dictate to Health Canada specific target populations; it did, however, make it clear that programs were to be more targeted to high-risk groups than in Phase I. Some Health Canada programs are not easily amenable to restriction in this way. For example, the Health Protection Branch laboratories analyze drug samples for police forces to assist in prosecutions and in certain types of investigations. Their responsibility is to analyze those samples sent to them by the police. They cannot restrict their activities to only certain types of samples or to those sent by only specially targeted police forces. Health Canada's laboratories are the only sources of this

service in Canada. Consequently, the issue of targeting does not arise for this specific activity; and there are other examples where the new directive for restricted targeting does not apply.

Nevertheless, this shift towards high-risk sub-populations marks a significant change for Health Canada. During Phase I, the Drug Strategy gave attention to the general population; this was motivated in part by the view that it is best to direct government efforts towards preventing non-consumers from becoming consumers and non-abusers from becoming abusers and to raise public awareness about the issues. Phase II moves away from primary prevention in favour of a concerted effort to grapple with the problems of the high-risk population, including those who already have serious problems with psychoactive drugs. To a significant extent, this decision was made on the basis of consultations with the provinces carried out in 1991 by the Canada's Drug Strategy Secretariat. However, this change did not come without controversy; there remain some provinces and some special interest groups who continue to maintain that it is more effective to target to general population and, some argue, to do so with the intention of promoting abstinence rather than keeping harm levels to a minimum. And, in some provinces, budget cuts have brought about reductions in funds for prevention programs for the general population. This report can neither vindicate nor refute the decision to change program targets, but it is hoped that the final evaluation will be able to begin doing so as data become available on trends in mortality and morbidity levels and on other indicators of effectiveness.

It is Health Programs and Services Branch programs that are most subject to the demand for more restrictive targeting. Medical Services Branch has a program for off-reserve aboriginals specifically targeted towards those at risk of solvent abuse, and the Health Protection Branch retains its programs directed towards the health professions and those others in the prescription drug supply chain specifically in its jurisdiction. These HPB targets, however, predate Canada's Drug Strategy. But it has been mostly the Health Programs and Services Branch that has responded to the government's call for more targeting to high risk populations in Canada's Drug Strategy, Phase II.

Health Programs and Services Branch

The Health Programs and Services Branch social marketing, research, and community support programs (a grants and contributions program) are to be directed towards high risk populations whereas in Phase I they were delivered to the general population, most of whom are low

risk. This is a change of great magnitude. Comparatively little is known about many high risk groups, some like homeless youth are extremely difficult to reach, and there is little precedent for how to deal with them effectively.

Targets

This Branch has selected five high risk populations:

- children, youth, and young adults, particularly out-of-the-mainstream youth (dropouts, homeless, street youth)
- women, especially those who misuse prescription drugs or alcohol
- seniors who mis-use prescription drugs or who combine drugs and alcohol
- off-reserve aboriginals
- those convicted of impaired driving.

The social marketing and community support programs no longer target the general population and have assumed that the provinces are providing adequate prevention services to low risk Canadians. Interviews with representatives of the provincial and territorial addictions services agencies heard that, especially in the poorer provinces, there is a great reliance upon Health Canada grants and contributions programs for their community alcohol and drug programming; consequently, this shift in targets has meant the loss of community-based programs targeted towards the general population for these provinces. The operating assumption underlying this change in targets does not hold for all provinces, and some representatives of the poorer provinces expressed the danger that consumption rates among the general population will rise as a direct result of the absence of primary prevention. During interviews, some provincial representatives voiced opposition to the target changes, although most were in agreement. This is not intended as a criticism of Canada's Drug Strategy. The targets were, after all, developed in concert with the provinces during the 1991 consultations. Nevertheless, the current concerns of some provinces ought to be known to Drug Strategy officials.

Implementation

Shifting programming from the mainstream population to high-risk groups has been difficult for this some parts of this Branch, according to those who were interviewed. During Phase I, their social marketing and grants and contributions programs were set up for the general population; the information disseminated was tailored to this audience, as were the methods of dissemination; the funding criteria were

designed for targets for the general population, and those in the communities who applied for funding were accustomed to drafting proposals for programs for the general public. With the change, this background, developed over many years, lost much of its relevance. If one is designing a social marketing program for out-of-the-mainstream-youth, the message, the methods of dissemination, and the methods for evaluating their effects must be different. Unfortunately, to do this is to break new ground, and it would appear that, at the inception of Phase II, the Branch was not well prepared to do so, at least not quickly. This is understandable because of the fact that the targets were decided only in March of 1992. Selective targeting is an important way to increase cost-effectiveness, but it has costs of its own when the target shift is as great as for this Branch.

The social marketing programs have been able to begin work with out-of-the-mainstream-youth and aboriginals, but have not yet begun designing programs for the other three groups. The Education and Training Unit of the Health Promotion Directorate has also experienced difficulties in adapting to the shift in target populations. In the past, for example, they dealt with organizations in the education system, delivering programs to the general population through the schools. Now that the focus is on high-risk populations, the schools are no longer the appropriate location to deliver the program; their audiences are more on the streets than in the schools. (However, some of the projects funded through grants and contributions seek to use the schools as one gateway to high-risk youth.) Therefore, not only has the Unit had to develop new programs, but they have had to establish new venues for delivery and establish partnerships with a different array of organizations. Because the shift to high risk populations requires using altogether different programs, the Training Unit has been involved in seeking programs that are effective from amongst the array offered in the provinces by a wide variety of organizations, many in the mental health or social services field. Putting actual programs into place will need to wait until these developmental steps are completed.

The community-funding program of the Health Programs and Services Branch is in a somewhat easier situation given that the shift in target population is essentially to be carried out by those who submit proposals. Program officials maintain that they are having no difficulty receiving proposals for projects directed towards the selected target groups. Because this is a regionally administered program, the emphasis amongst the five targets varies from region to region; the

determining factor is the interests of those who submit proposals for project funding. Similarly, the National Health Research and Development Program can rely upon those researchers whom it funds to carry out the shift in targets. The NHRDP had to develop new Requests for Research Proposals and did so in consultation with members of the research community, non-governmental organizations, departmental and provincial representatives; this activity helped to define gaps in knowledge and thus to clarify the research priorities, which enabled the release of a request for proposals.

Health Protection Branch

The contributions to Canada's Drug Strategy of the Health Protection Branch are, for the most part, a continuation of program activities that they have conducted for many years. The Drug Strategy has provided additional funds for this work, but their targets have remained the same. The reason for this is quite straightforward. In general, the Health Protection Branch contributes to the Strategy by enforcing or helping to enforce the Narcotic Control Act and Parts III and IV of the Food and Drugs Act and their regulations. They do this by monitoring prescription records, inspecting various points in the chain of the manufacture and distribution of prescription psychoactive drugs, by analysing samples of drugs seized by the police, and by helping to draft legislation and regulations. This sort of work is immune to the particular changes in target group specified by the Memorandum to Cabinet for Canada's Drug Strategy.

There is, however, another sort of targeting issue that can be raised here. In 1992, the report and recommendations of the evaluation of the Dangerous Drugs Program was approved by the Department. One of the recommended changes to this program concerned the target group of those involved in "multi-doctoring". This is the practice of an individual who receives prescriptions of psychoactive drugs from more than one physician at roughly the same time. This is an illegal act except in special circumstances. The Health Protection Branch attempts to detect violators by analysing prescription records and will turn over suspected cases to the RCMP for action. The evaluation recommended that, because this activity appeared not to be cost-effective, it be diminished or discontinued. The Branch continues to carry out this activity, but at a rate somewhat reduced from that of 1992. There is no evidence to suggest that this activity is significantly more cost-effective today than at the time of the evaluation. And it

remains just as true today that the resources expended on this activity could, in general, be better spent elsewhere.

The Branch has entered into negotiations with some provinces, most notably British Columbia and Quebec, to have their licensing authorities take on this responsibility. If these negotiations succeed, pilot projects will be set up and, if successful, may convince other provinces to follow suit. Because of the computerized prescription systems in these two provinces, the surveillance will be done electronically. However, not all provinces are so equipped and it is unlikely that they would agree to accept the job of monitoring prescriptions until their prescription records are fully computerized in a single system. Nonetheless, the step of transferring responsibility should help the Branch shift its focus to more cost-effective activities.

There remains the broad question of whether it is useful for anyone to examine prescription data for this purpose. The arguments cited in the evaluation report were general; their point is that this simply is not a cost-effective activity whether it is done by the federal government or by someone else.

Medical Services Branch

The Medical Services Branch, too, has been little affected by target changes in Canada's Drug Strategy. Its Drug Strategy programs have always been targeted towards one of the designated high risk groups, the aboriginal population. In the past, the Branch's programs were mostly restricted to on-reserve aboriginals, but in Phase II of Canada's Drug Strategy, the Addictions and Community Funded Program expanded to include off-reserve aboriginals, especially those who are at high risk of solvent abuse. Like its on-reserve counterpart, this program assists communities to deliver culturally specific substance abuse prevention programs; their major partner is the National Association of Friendship Centres.

OTHER STRATEGIES

Canada's Drug Strategy is not alone in delivering programs to people whose health and well-being are at risk. Other of Health Canada's programs and other inter-departmental strategies that the Department participates in target high-risk populations. Further, it is often the case that their targeted populations overlap, that it is the very same people who are the targets for different strategies and programs. As programming is now organized in Health Canada, it is problems that are the primary targets with attention to sub-populations being

secondary. That is, once one has targeted a problem, one then can proceed to target specific sub-populations that suffer from that problem. However, a determinants of health approach might suggest a targeting primarily of populations because it is known that certain populations suffer from a wide variety of health problem. There is a significant policy question that can be raised here, but which this study has no mandate to answer. The question is whether interdepartmental strategies should be defined according to problem or according to those sub-populations that suffer from multiple problems. More of this is contained in chapter 6 of this report.

SUMMARY AND CONCLUSIONS

By directing its programs to more selective targets, Canada's Drug Strategy, Phase II intended to become more effective. In principle, this should be an improvement over an approach that "targets" everyone in the hopes of reaching those at high risk or preventing low-risk sub-populations from becoming high-risk. In some fields of programming, such an approach will not reach high risk groups. Social marketing programs are a good example of this. If one wants to convey information through television, it will not reach those who do not use a television. Homeless young people are often in this situation. Thus, targeting this group as a special case rather than just as a subset of the entire population could have benefit, assuming that there are effective ways to reach this sub-population.

The shift in targets, a shift from primary to secondary prevention, is accompanied by the harm reduction approach that Canada's Drug Strategy, Phase II, takes to substance abuse in Canada. While Canada's harm reduction approach does not condone substance abuse, it does accept it as a fact of our society and maintains that it is unrealistic to expect abstinence programming to succeed (except for children) in an environment characterized by substance abuse problems. Again, it remains for the final evaluation of Canada's Drug Strategy to assess the effectiveness of this change in target.

It is only in the Health Programs and Services Branch that Health Canada programs have initiated significant changes to their program targets. The reason would appear to concern the specific sorts of targets mentioned in the Memorandum to Cabinet, listed above on page 9. The Medical Services Branch was already working with one of these groups and the work of the Health Protection Branch is largely immune to change from these particular targets. It does not follow, however, that these two Branches ought not consider the

potential benefits of more selective targeting in their programs. One example has already been mentioned concerning the Health Protection Branch, and, in principle, the Medical Services Branch could be more selective in its targets within the aboriginal population, if this should prove warranted. (It must be borne in mind that the Medical Services Branch's ability to target is somewhat limited by the high degree of autonomy that recipient communities have over the use of Canada's Drug Strategy funds.) These possibilities appear not to have been countenanced by these Branches in designing their Phase II programs. The next few years will be years of tight budgets. One can expect that selective targeting will remain an important vehicle for making most effective use of scarce resources.

chapter 3
co-ordination

BACKGROUND

An assumption underlying the evaluation work already done and that is yet to be done is that co-ordination is essential to Canada's Drug Strategy. Co-ordination is what will make a set of autonomous alcohol and other drug programs a single strategy; without co-ordination, one can have a strategy only in name. Adding resources to programs does not make the result a strategy, even if the resources are approved under a single Memorandum to Cabinet. Similarity of target does not in itself make a set of programs a single strategy. And having better information for policy and programming decisions does not make a set of programs a strategy. It is co-ordination that makes strategies, and it is its performance in especially this area that will determine the success of this experiment in inter-departmental programming.

Some unknowns

Although co-ordination was to be a crucial element of Phase I of the Drug Strategy, it was judged weak and was to be strengthened in Phase II. It was for this reason that the government created the Canada's Drug Strategy Secretariat. However, as the mid-term review report for the Strategy overall states, and as the Evaluation Working Group reported early in 1993, there are no explicit or detailed co-ordination goals for Canada's Drug Strategy. This lack of goals has affected the Strategy overall and also Health Canada's components. At the outset of Phase II, it was unknown to Health Canada officials what co-ordination activities or outcomes were expected.

More specifically, there were no known answers to such basic questions as,

- "Is Health Canada expected to increase co-ordination between Branches?",
- "Is Health Canada expected to increase co-ordination only within the confines of individual programs, and therefore

between individual programs and other organizations it may happen to work with?", or

- "Is Health Canada expected to increase co-ordination between its activities and those of other federal departments?"

There are many such questions to which this mid-term review was unable to gain responses. Treasury Board officials stated that it was the responsibility of the Department, in so far as it has the lead role, to develop its specific co-ordination goals. At the same time, the Canada's Drug Strategy Secretariat lamented the lack of direction from the central agencies of government.

As a result, the mid-term review will not be able to answer the question, "Has Health Canada met its co-ordination goals for Canada's Drug Strategy?", because these goals do not exist as such. This does not imply that there are no examples of co-ordinated activity within the Department's alcohol and drug programs. Indeed such activity exists, some of it the result of direct action on the part of the Canada's Drug Strategy Secretariat and some the result of program specific decisions. An underlying and at times difficult-to-answer question will often be present in this discussion, namely, to what extent are examples of co-ordination the result of Canada's Drug Strategy or the result of individual programming decisions that would have been made in the absence of the Strategy? But it must be stressed that co-ordination is weaker than it need be, and one reason is the absence of a co-ordination plan that defines clearly what co-ordination means within Canada's Drug Strategy, and what Health Canada was to achieve in this regard.

CO-ORDINATION WITHIN PROGRAMS

Many individual programs that fall under Canada's Drug Strategy are involved with other organizations, some within and some outside government. Clear examples of this sort of relationship obtain with grants and contributions programs such as the "Community Support Program" of the Health Programs and Services Branch and the "Addictions and Community Funded Programs" of the Medical Services Branch. Informal "partnerships" are important to these types of program. Their proper functioning requires a co-ordination of effort between headquarters and regional staff, and often staff from provincial governments or native organizations as the case may be. Similarly, the Health Protection Branch laboratories must co-ordinate their drug analysis work with the law enforcement agencies who are their client. Often, this program-specific co-ordination is very important to their effectiveness. However, this sort of co-ordination is

a straightforward condition of good management, not an added benefit brought about by Canada's Drug Strategy. It is the sort of co-ordination that one would expect even in the absence of the Drug Strategy and often pre-dated its existence. This report does not intend to diminish the importance of this co-ordinated effort; a review of specifically such a program on its own would undoubtedly draw attention to it. But again, this review is of the value added by Canada's Drug Strategy to Health Canada's alcohol and drug programming.

CO-ORDINATION BETWEEN HEALTH CANADA PROGRAMS

The mid-term review searched for evidence of co-ordination that was brought about by Canada's Drug Strategy and that made a discernable difference to the way that Health Canada's drug programming was carried out. The review does not regard pre-existing co-ordination arrangements as evidence of the benefits of Canada's Drug Strategy. Of special interest are newly developed activities and mechanisms that bring about co-ordination between programs within the Department. Herein lies some of the greatest potential for improved program effectiveness and cost-effectiveness, the raison d'être for creating the Strategy in the first place. Four Health Canada Branches are involved in Canada's Drug Strategy, are components of a single initiative with a common, albeit vaguely defined, objective to reduce harms caused by problem use of alcohol and other drugs.

One would expect that a high degree of co-ordination would result from the fact that Health Canada is the lead department in an initiative that characterizes substance abuse problems as health problems; has the lead in policy development and the responsibility for drafting new legislation; has stressed the need for co-ordination in the Memorandum to Cabinet and in many of its internal management documents; and has portrayed itself as having a national leadership role in health issues.

Indicators of co-ordination

What one would expect within the Department, and what would indicate good co-ordination and a collective sense of "strategy" include the following:

- a common understanding and acceptance of the objectives of Canada's Drug Strategy;

- a clearly defined and commonly accepted set of co-ordination goals for Health Canada's contributions to Canada's Drug Strategy;
- a Departmental policy framework under which are systematically located its diversity of alcohol and drug programs;
- a strong organizational mechanism for co-ordinating planning, policy, and program delivery;
- a strong system of information flow to ensure rational, evidence-based planning, policy development, and program delivery;
- a capacity to mobilize and take fullest advantage of the skills of the other participating departments in dealing with Canada's alcohol and drug problems;
- sharing costs and responsibilities between responsibility centres; and
- a capacity to deal with emerging issues or dramatic changes in the nature of Canada's drug problems.

Some of these indicators are stronger than others; this mirrors the fact that the concept of co-ordination is ambiguous. Just what is an acceptable degree of co-ordination among the participants in Canada's Drug Strategy cannot be answered unequivocally by this review because there are no agreed upon standards to which it can appeal. It can be hoped, however, that the review will bring it about that co-ordination goals and standards are developed by Health Canada for the purposes of not only Canada's Drug Strategy but other multi-departmental initiatives in which it participates and for which there are no clear co-ordination goals.

Expectations of co-ordination

It should be stated that the mid-term review heard the view expressed that one should not expect more by way of co-ordination than that the programs covered by the Memorandum to Cabinet are actually being carried out and that they do not conflict with one another. The assumption here is that the Memorandum to Cabinet was drafted in such a way that if the programs are actually carried out as planned, the result will be a co-ordinated contribution by Health Canada, and that there is no need for more overt expressions of co-ordination. This opinion is not without interest. A Memorandum to Cabinet that proposes a coherent system of programs should well result in a co-ordinated system of programs, at least in the sense that they do not conflict with one another or reduce each other's effectiveness. This weak sense of co-ordination, however, should be a normal part of

government business, but not the special objective of an initiative like Canada's Drug Strategy. Something stronger is wanted by co-ordination in the Drug Strategy than routine sound management practices. Indeed, the Memorandum to Cabinet explicitly calls for stronger co-ordination. It is for these reasons that the mid-term review appealed to stronger indicators of co-ordination.

Early warning signs

An early indication that co-ordination across the Strategy might be difficult to accomplish appeared during the planning stages of the evaluation in mid-1992. The Inter-departmental Evaluation Working Group met with a committee of officials of Canada's Drug Strategy to learn what were the "strategic" objectives against which to evaluate its performance. This first experience of the evaluation team was revealing of how far the Inter-departmental Program Working Group[2] had come in cultivating a sense of common purpose, of a common understanding in its mission, of being partners in a shared enterprise. These first experiences were of a group easily able to represent the interests and purposes of the programs its members were directly involved in delivering, but less able to speak as members of the same team. What is noteworthy is that the Program Working Group had a difficult time coming to grips with the notion of strategy-wide objectives at all, let alone with specifying what they were. In other words, there seemed to be little sense of common purpose or common understanding among the members of this committee. Because multi-departmental strategies were a rather new form of government intervention, this, perhaps, should not be a surprise.

The Strategy seemed, at that point, a set of individual and autonomous programs linked only by a common Memorandum to Cabinet that dealt with supplementary funding. To a significant extent, this remains the case at the time that this report was drafted.

Health Programs and Services Branch: The Alcohol and Other Drugs Programs Unit

The Health Promotion Directorate of the Health Programs and Services Branch has created an organization called the Alcohol and Other Drugs Programs Unit and given it responsibility for co-ordinating the Directorate's contributions to Canada's Drug Strategy and responsibilities for managing, planning and evaluating these contributions. This unit has been very active in trying to bring a degree of co-ordination to the Strategy, and its efforts appear to be appreciated by those with whom it works. The Unit interacts with organizations within its Branch including the Canada's Drug Strategy Secretariat, within Health Canada, within the federal government, and

with provincial organizations and non-governmental organizations in the alcohol and drugs field.

Among other activities, it has worked with the Canada's Drug Strategy Secretariat, for example, on their series of workshops on the topic of out-of-the-mainstream youth, one of the prime targets of Phase II; it has organized a series of national round tables to discuss alcohol and other drug-related issues of concern to women and to seniors; it is involved in some policy development; and it helps to co-ordinate research, especially regarding the targets of the Health Promotion Directorate's programs.

The provinces

Of interest to this review is how Canada's Drug Strategy involves the provinces, crucial players in the system of alcohol and drug programming in Canada. The Memorandum to Cabinet recognizes the province's role in this field and stresses that they be included in the co-ordination effort. Their contributions include, prominently, addictions treatment where they are the major service provider, a wide range of prevention programming, research (especially in Alberta and Ontario), and law enforcement and regulation (especially for alcohol and prescription drugs). In other words, the provinces, too, have programs in all three general areas of the alcohol and drug field: prevention, treatment and rehabilitation, and law enforcement. And at least two provinces, Ontario and Quebec, have their own formal Drug Strategy. The potential for co-ordination is vast; unfortunately, much of the potential remains to be taken advantage of. This review is concerned that it was unable to determine what organization has responsibility for federal-provincial co-ordination for Canada's Drug Strategy.

Co-ordination worse with provinces

If there is a general lesson to be learned about co-ordination from the experiences of Canada's Drug Strategy, it is that co-ordination does not happen of its own accord. It must be made to happen, be explicitly the responsibility of an organization that is recognized and accepted as having the responsibility, and there must be mechanisms, be they committees or working groups, to carry it out. At the time that this report was written, there were no mechanisms in place to systematically look after federal-provincial co-ordination on alcohol and other drug issues. The result is predictable. In interviews with representatives of each provincial or territorial organization charged with alcohol and drug programming in the prevention field, 100% expressed the opinion that co-ordination had worsened since Canada's Drug Strategy was renewed in 1992, that co-ordination was better

under Phase I. And recall that co-ordination was singled out for improvement during Phase II.

Responsibility Unclear

If there is a single most often-cited reason for this perception, it is the dissolution of the Federal-Provincial Advisory Committee on Alcohol and Other Drug Problems in 1990 and the fact that no other organization has taken on its functions. This committee, together with its variety of sub-committees and working groups, is regarded by many in the prevention field as having been the most important vehicle for co-ordinating federal and provincial programs and policies. The Committee was active in a wide range of concerns and it produced many education and training, public awareness, research, and community development resources. Importantly, it was recognized and accepted as the vehicle for co-ordination. Now, it is quite unclear who is responsible for federal-provincial co-ordination, what form co-ordination is to take, and within what forum it is to be brought about.

One might think that the Canada's Drug Strategy Secretariat would be responsible, given that it has a broadly stated mandate for co-ordinating Canada's Drug Strategy. However, they are not involved with provincial officials, except on an ad hoc and bi-lateral basis. It is believed by most provincial officials interviewed that the Secretariat is responsible for co-ordination between federal departments, not between federal and provincial governments. And the Secretariat argues that they cannot convene meetings of all provincial and territorial officials on the grounds that to do so would be tantamount to re-creating the Advisory Committee.

In 1991, the Secretariat, in preparation for the renewal of Canada's Drug Strategy, held a series of consultations across Canada to learn the views of a wide variety of officials on the nature of Canada's drug problem and what the federal government should do in the second phase of the Strategy. This was the last time that the Secretariat has been able to meet with provincial officials, except for bi-lateral discussions, and the last time that some provincial officials reported having heard from them. Again, the roles and responsibilities of the Secretariat with regard to the provinces are unclear. The mid-term review was unable to determine why this is the case.

Almost without exception, those interviewed believe that there needs to be a formal mechanism created if the federal government is to be able to act in the prevention field in a co-ordinated fashion with the provinces. In theory, the Advisory Committee on Population Health is

to have responsibility for the drug file, but this mid-term review was told that it has not yet raised this issue during any of its meetings.

This report will remain silent on whether the Federal-Provincial Advisory Committee on Alcohol and Other Drug Problems should have been dissolved. However, it does note the discrepancy between the concept of Canada's Drug Strategy as a co-ordinated initiative involving provincial programming and the reality of the situation, a reality in which co-ordination is lacking and in which there exists no formal means for bringing it about. This review recalls that the federal and provincial/territorial governments worked together for many years to develop policies and programs through the Advisory Committee and its sub-committees and working groups and that this co-ordination preceded Canada's Drug Strategy. It is surely an irony that, while Canada's Drug Strategy attempts to improve co-ordination, an important mechanism for doing so between governments is dismantled.

The Alcohol and Other Drug Programs Unit's role with provinces

The Health Promotion Directorate's Alcohol and Other Drug Programs Unit has been involved in discussions with officials from the provinces and territories. For example, it created a Federal-Provincial/Territorial Research Committee to prepare for the Canada Alcohol and Drug Survey. And it has recently, for the limited purpose of discussing research and prevention program activities, brought representatives from the provinces and territories together. They have held two meetings since the beginning of Phase II. All provincial and territorial representatives value these opportunities for joint discussions, but they recognize that they are of limited scope and cannot replace the activities and therefore cannot reap all of the benefits possible through the Advisory Committee or another sort of permanent structure. The Committee allowed for co-ordination amongst the provinces and territories as well as between that level of government and the federal government. The Health Promotion Directorate meetings, to a large extent, are for sharing information.

The federal-provincial co-ordination role being played by the Alcohol and Other Drugs Programs Unit, while welcomed by them, has added to the provinces' confusion over who represents the federal government. From their point of view, there are now three federal organizations, the Secretariat, the Canadian Centre on Substance Abuse, and the Health Promotion Directorate. Some of them were uncertain whom they should contact as the spokesperson for the federal government.

NHRDP and Other Research Programs

Although this mid-term review treated the Strategy's information base as a separate issue, the development and dissemination of information is, in part, a co-ordination issue. The Health Programs and Services Branch conducts or funds a high proportion of the Department's alcohol and drug-related research, but it is not the only Branch in the research business. There is a great potential for co-ordination with regard to research and information, and it would certainly be in the spirit of Canada's Drug Strategy that this potential be exploited.

There are examples of co-ordination directly attributable to Canada's Drug Strategy. Under Phase II, the National Health Research and Development Program was to change its research targets to high-risk groups, as required by Cabinet. Before announcing a "Request for Research Proposals", NHRDP staff met with representatives of the research community and government to discuss research priorities. In drafting the "Request for Research Proposals", the NHRDP worked with the Canada's Drug Strategy Secretariat and the Health Promotion Directorate's Alcohol and Other Drugs Programs Unit. Unfortunately, despite the planning intended to generate proposals from other than academic institutions, from organizations like the Addiction Research Foundation or the Canadian Centre on Substance Abuse, there were none. The response to the RFP was not great, according to program officials, and what responses they received were mostly from the university community. The Department, even though it is to be the first direct beneficiary of the research done through NHRDP, was not forthcoming with suggestions of what sort of research in the drug and alcohol fields would be useful. This suggests that there is no department-wide research plan or planning mechanism for Health Canada on this set of issues. This runs counter to the demands expressed in the Memorandum to Cabinet for more co-ordination and for a stronger information base for Canada's Drug Strategy.

Health Canada's 1994 evaluation of the NHRDP found that the dissemination of information produced through the program could be improved and noted that some researchers' reports are written more for academic audiences than for policy or decision makers. This, together with the absence of a co-ordinated research plan, indicates a gulf between Health Canada's or Canada's Drug Strategy's research needs and the production of extramural research. There is little evidence to suggest that the research needs of Canada's Drug Strategy are co-ordinated and communicated to the researchers or that their products reach those within Health Canada in such a way that they are used for policy setting or program design. More will be said about

this and about the Health Programs and Services Branch "Canada's Alcohol and Other Drugs Survey" in the section on information.

Health Protection Branch

The Health Protection Branch's programming was little affected by Canada's Drug Strategy, as was noted in the discussion of targets. This seems to hold true with regard to co-ordination between programs, too. The interviews did not yield evidence of increased co-ordination brought about by the Branch's participation in Canada's Drug Strategy. What emerged from the interviews was a picture of a Branch that is rather isolated in its work from the rest of Health Canada. A number of Branch staff commented on the Canada's Drug Strategy Secretariat's interference in their program operations, and some Secretariat staff commented on the lack of willingness in the Health Protection Branch to work co-operatively with others in the Strategy. This concerned, for example, the process to draft the legislation known as Bill C-7 and general information-sharing.

To a certain extent, that the Health Protection Branch's programs are supply control and not demand reduction programs explains the lack of co-ordination: they are, at first glance at least, in a rather different business from the rest of Health Canada's Drug Strategy programs. On the other hand, there exists potential for co-ordination. That a program is a supply reduction program does not in itself mean that it is of no interest to a demand reduction program. An underlying premise of Canada's Drug Strategy is that benefits will arise from co-ordinating supply reduction with demand reduction activities. Otherwise, there would be little sense to having a single comprehensive Strategy.

Where co-ordination often begins is with exchanging information of mutual interest. The Health Protection Branch has enormous amounts of information on matters related to psychoactive drugs: prescription records that indicate, for example, usage and diversion trends, crime records, current records of seized drugs that indicate what drugs are appearing on the black market, and information on the effects of specific drugs on persons. There is, however, little evidence that this information is used outside the Branch for program design or policy development. Much of this information could be useful in designing demand reduction programs, especially now that the government is more inclined to target programs more specifically than before.

Medical Services Branch

The Drug Strategy programs that the Medical Services Branch offers are mostly in the form of grants and contributions to communities who use the funds for health promotion and other sorts of interventions to prevent substance abuse. The programs are administered in the regional offices who attempt to co-ordinate their efforts with the communities and to encourage them to try to co-ordinate related programs within their communities. This sort of co-ordination is to be expected of this sort of program, and is not the result specifically of the call for co-ordination by Canada's Drug Strategy.

In Phase II of Canada's Drug Strategy, the Medical Services Branch has a program for off-reserve aboriginals, with the main target being youth at risk of abusing solvents. This program is delivered by means of Branch headquarters administering project proposals. The Health Programs and Services Branch plays a role in proposal selection. Off reserve aboriginals were also among the targets of the Health Programs and Services Branch's public awareness program, policy development, research and evaluation in the Alcohol and Other Drugs Programs Unit, and the community grants and contributions program. The Health Programs and Services Branch collaborated with the Medical Services Branch in developing their off-reserve programs and the two Branches speak of good co-ordination between them. The intention is to not only improve programming but to prevent duplication and avoid program gaps. This is a laudable and sensible approach to a situation where two branches are charged with delivering similar programs.

Summary

There exists within Health Canada no organization to foster co-ordination amongst programs in different Branches. Only in the Health Programs and Services Branch is there a body with the responsibility to co-ordinate a Branch's activities under Canada's Drug Strategy. However, its role remains primarily in-Branch. It comes as no surprise, then, that there is relatively little co-ordinating activity between the programs of different Branches. The main exception made known to this review was the collaboration regarding off-reserve aboriginal programs.

Furthermore, there are no co-ordination goals for Health Canada programming. One might argue that this by itself is no reason for criticism, that no more co-ordination is required for effective programming. However, there is prima facie reason to think that programming could be made more effective through co-ordinated

efforts between the programs of the different Branches, and it behooves Health Canada to examine the possibilities in the spirit of the Drug Strategy; after all, each program under the Strategy has the same general objective of reducing drug-related harm to Canadians.

A few examples of possible areas of co-ordination at a policy or strategic planning level present themselves immediately:

- a large amount of research is conducted through the programs of each Branch. Co-ordination could optimize decisions about what research needs to be done, could optimize the distribution and use of its results, and could prevent any duplication arising from the multiplicity of research activities done under the Strategy.
- Health Canada's three program Branches engage in prevention programs to reduce the demand for psychoactive substances. There is a potential for co-ordinating information about what sorts of prevention interventions work best for certain types of audiences. This information could also be of benefit to other Departments who deliver demand reduction programs.
- similarly, the potential exists for joint program design within the program Branches, at least with regard to demand reduction programming, if not with regard to supply control programming, too.
- the three program Branches and the Policy and Consultation Branch develop policy on different aspects of alcohol and other drugs. Co-ordinating these policies seems to be a missing component of Canada's Drug Strategy at Health Canada. (This may be corrected to a certain extent if Parliamentary Committee on Health conducts a review of current drug policy following the passage of Bill C-7. The Canada's Drug Strategy Secretariat would play a role in the process which would likely include developing a Health Canada position.)

For years, it has been said that the Branches of Health Canada tend to operate in isolation from one another, and for years it has been said that this may reduce the overall effectiveness of the Department's activities. Canada's Drug Strategy has been an opportunity to "break down the stovepipes"; to an unnecessary extent, it appears to have been a missed opportunity.

CO-ORDINATION BETWEEN HEALTH CANADA AND OTHER DEPARTMENTS

To this point, the report has not addressed co-ordination between Health Canada and other departments. As is the case for programs within the Department, there is no overarching plan for co-ordinating the activities of Health Canada with those of other Drug Strategy partners. There are, it must be emphasized, linked activities, but for the most part, these pre-date the Strategy or result not from the Strategy itself but from normal requirements of proper management or program delivery. In other words, most of the co-ordination that exists between Health Canada and other departments would have existed even in the absence of the Strategy.

An example will illustrate the point. The Health Protection Branch provides drug analysis services to the police to assist in prosecutions and in some complex investigations. The interactions are of a client-service provider sort. The level of analytical activity is determined by the demand for services. In so far as the Branch laboratory work functions in a chain of events leading towards a prosecution, the work is co-ordinated with the other activities in the process. This sort of co-ordination is not the product of Canada's Drug Strategy but pre-dated its call for co-ordination.

What is new with Phase II of the Strategy are the Integrated Anti-Drug Profiteering Units in Vancouver, Toronto, and Montreal. These units are, in effect, demonstration projects to test a system designed to strike at the profits made from drug crimes. The Units are co-ordinated by the Solicitor General Secretariat and include the RCMP, Canada Customs, the Department of Justice, and Health Canada which contributes drug analysis services. Originally, Health Canada was to participate also by continuing its responsibility for managing seized and forfeited assets; however, this task has resided with Public Works and Government Services Canada since September, 1993.

In actual fact, the Department's role in these highly co-ordinated units is peripheral. Health Canada appears not to do anything in addition to the drug analysis it did before the creation of the Integrated Anti-Drug Profiteering Units. For example, the co-ordination committee structure for the project does not include a representative from Health Canada because it has not been invited to join. Further, these pilot units are subject to annual evaluations. The reports to date have not included discussions of Health Canada's role in their work. And, the September, 1994 evaluation workshop on this project, sponsored by the Solicitor General Secretariat, did not include a representative from the Health Protection Branch even though it did include

representatives from the Canada's Drug Strategy Secretariat and even from the private sector. If the pilot units were to benefit from the active involvement of Health Canada in co-ordination, one must surmise that these added benefits are missing. It must be added, however, that there is a recognition of the high quality of work that the Department's laboratories do in support of the units' investigations.

Interdepartmental Committee

There exists an organization, the Interdepartmental Committee for Canada's Drug Strategy, chaired by the Canada's Drug Strategy Secretariat, that was established by Health Canada to foster co-ordination amongst the federal partners. Members are program managers from each participating department, but it appears dominated by Health Canada because of the large number of programs that are represented. This committee has the greatest potential for developing co-ordination at the program level, but, as is described in the inter-departmental mid-term review report, it has failed to live up to its potential and has not met for many months. The meetings are for purposes only of sharing information. It has been unable to co-ordinate beyond that point, and even the sharing of information is limited, the greater part of it coming from the Canada's Drug Strategy Secretariat. Most representatives from the participating departments remain silent during the meetings.

Steering Committee

Another organization with potential to co-ordinate between departments is the Interdepartmental Steering Committee. This committee was established in 1992 as a steering committee for the evaluation of Canada's Drug Strategy. However, because of the lack of any committee of senior managers to steer the Drug Strategy itself, the Program Evaluation Division of Health Canada worked with the Canada's Drug Strategy Secretariat to have the committee's mandate expanded to include steering the Strategy itself, not just its evaluation. The new mandate was adopted by the Committee only in late 1994. More on this Committee is contained in the inter-departmental report.

CANADA'S DRUG STRATEGY SECRETARIAT

The responsibilities of the Canada's Drug Strategy Secretariat for co-ordination within Health Canada are unclear and have been unclear since its inception in 1990. The Secretariat was created by Health Canada to develop the Memorandum to Cabinet for the renewal of the National Drug Strategy. In this capacity, it was responsible to consult with the Strategy "partners" and to co-ordinate the renewal process. (Actual drafting of the Cabinet document was done by the Policy and Consultation Branch of Health Canada.) By renewing the Strategy,

Cabinet at the same time retained the Secretariat, gave it four key responsibilities, but did not specify any one of them in detail. As a consequence of these details not being developed in the meantime, there exists a considerable amount of confusion within and outside Health Canada over what are the responsibilities and authorities of the Canada's Drug Strategy Secretariat. This confusion, has meant for less effective co-ordination than would be otherwise possible. It is not in the interest of this report to attempt to determine responsibility for the existing confusion, only to make it known in the hope that it is corrected.

Confusion about its role

The confusion is shared by program mangers and Secretariat officials alike. Following the submission of a baseline data discussion paper by the Inter-departmental Evaluation Working Group which noted the lack of co-ordination goals for the Strategy, the Canada's Drug Strategy Secretariat took the step of conducting a series of bi-lateral meetings with the members of the Interdepartmental Committee in an attempt to learn what ought to be its role. The results were equivocal, with no clear direction coming from these meetings and no direction taken by the Secretariat. This situation remains. There is quite simply no clear and shared view of what is or ought to be the role of the Canada's Drug Strategy Secretariat. Those responsible for drug programming in the provinces, as noted before, regard them as having a role only at the federal level. Many program officers at Health Canada regard them as having a role only in co-ordinating between federal departments and on matters of policy, not programming; some within Health Canada regard them as having a stronger concern for law enforcement than for health issues. And it is commonly believed outside of Health Canada that the Secretariat is primarily a Health Canada institution, having little bearing on the rest of the Strategy participants.

A further confusion, notable for its persistence, is over the roles of the Secretariat and the Canadian Centre on Substance Abuse. For years confusion has existed over the respective roles of these two organizations; despite attempts by both organizations to clarify their mandates and the differences between them, confusion remains. These problems can only weaken the ability of the Secretariat to act as a co-ordinator and can only weaken the benefits that were supposed to accrue to Canadians from co-ordinating the drug-related activities of the seven participating departments.

Organizational location

A question that arises in the context of the Secretariat's ability to co-

ordinate is that of its location. One can ask whether the central co-ordinating function of a multi-departmental initiative ought to be within one of the participating departments at all. It has been general practice, in the federal government, to place co-ordinating bodies of multi-departmental initiatives within the line department designated as the lead. The National Strategy for the Integration of Persons with Disabilities, for example, is co-ordinated out of Human Resources Development Canada. In this case, Health Canada has been designated as the lead, and it therefore seems most appropriate that the Drug Strategy Secretariat be located in that department. The fact that Health Canada has programs in both supply and demand reduction reinforces its suitability.

The question of location also arises within Health Canada itself. There are three line branches in the department that deliver autonomous Drug Strategy programs in both the supply and demand reduction sectors. Originally, the Secretariat reported directly to the Deputy Minister, then to the Associate Deputy Minister (1992), then to the Assistant Deputy Minister of the Policy and Consultation Branch (1993); in these reporting relationships, the Secretariat was independent of the line branches delivering Drug Strategy programs. In 1994 it moved to the Health Programs and Services Branch, reporting to the Assistant Deputy Minister, and now it reports to a Director General within that same Branch. This was a very recent move and it is too early to discern what effects it will have on the Secretariat's co-ordinating abilities.

The mid-term review did, however, indicate a perception within the Secretariat that its position as Strategy co-ordinator has been weakened by their being placed within one of the line Branches of Health Canada, a Branch that has a heavy responsibility for programs in the demand reduction area of Canada's Drug Strategy. This, they believe, makes it more difficult for the Canada's Drug Strategy Secretariat to convince other players within Health Canada and elsewhere in the federal government that they act on behalf of the entire Strategy. It is difficult to convince other departments to regard it as representing them and not just Health Canada, and it remains difficult for them to convince Health Canada that it represents them, too.

To what extent these organizational changes have affected the abilities of the Secretariat to co-ordinate amongst the federal departments is somewhat unclear. The mid-term review did not explicitly consider this particular issue. However, it would appear to be of sufficient

significance to study in its own right during the final evaluation, when the effects of these changes will be more fully evident.

Examples of Co-ordinating Activities

Most of the Secretariat's co-ordination work has been of an inter-departmental nature. Of special interest to Health Canada, it organized a workshop on out-of-the-mainstream youth that included participants from the Health Programs and Services Branch and organizations outside the federal government, and it has participated in numerous workshops and conferences arranged by others. The review notes that the level of the Secretariat's co-ordination activity has increased over the past few months from previous levels. For example, the Secretariat drafted in conjunction with Drug Strategy officials from each Branch and officials representing related initiatives such as the National AIDS Strategy and the Family Violence initiative, a departmental position on the vague and controversial concept of 'harm reduction'. To date, Health Canada is the only department to develop a position with regard to the meaning and implications of harm reduction in the drug field. It is important that Health Canada has done so given that Canada's Drug Strategy, Phase II distinguishes itself from its predecessor by explicitly assuming a harm reduction approach and adopting harm reduction as its core objective. It was unclear at the time that this report was prepared whether other participating departments agree with Health Canada's understanding of this key concept.

New Legislation

Bill C-7, the Controlled Substances Act, has provided another recent opportunity for the Canada's Drug Strategy Secretariat to co-ordinate within Health Canada. This draft bill, which has had a very long history predating Canada's Drug Strategy, Phase I, remains difficult and has been subjected to numerous changes. In order to provide the Parliamentary Committee with a Health Canada perspective on some the areas under recent discussion, the Secretariat has over the last six months brought together Drug Strategy representatives from each Branch at Health Canada as well as representatives from related Strategies, most notably from the AIDS Strategy, to develop a departmental consensus regarding aspects of the draft legislation itself and its policy implications. It should be noted that these discussions have been valued by those representing the AIDS Strategy. Not only have they been given an opportunity to make known how the legislation might affect their stakeholders, but they have been able to improve the level of understanding of the issues amongst their stakeholders. They noted their appreciation of the good flow of information between the two strategies on this issue.

No Program Role

This sort of co-ordination work is certainly to be valued. One notes that it is primarily of a conceptual nature, concerning policy and legislation and not programming. The Secretariat has, in general, been less than proactive in fostering the co-ordination of programming between the Branches of Health Canada. Why the Secretariat has not been more active in this regard within Health Canada may be explained in part by the view, widely held within the department, that the Secretariat must not play any sort of program role, that its main co-ordination responsibilities lie in co-ordination, not within Health Canada, but amongst the seven federal departments. This seems to have been taken to mean that the Secretariat can do nothing within Health Canada that it would not do with the other departments, for example, invite officials to meetings of the Inter Departmental Committee. There is some resistance, then, to the Secretariat taking on a strong role in co-ordinating programs.

This reasoning is curious, however. If the Canada's Drug Strategy Secretariat is to co-ordinate between departments, that would suggest co-ordinating the programs delivered by these departments. By and large, Canada's Drug Strategy is a set of programs and to co-ordinate it would seem to be to co-ordinate its programs. This would seem to apply to Health Canada, also. Those who oppose any Secretariat involvement in programs would seem to be saying that it is fine for it to co-ordinate the programs of other departments, but not those of Health Canada. One could argue, however, that the Secretariat is in a good position to identify potential areas where programs could co-ordinate their activities, be they direct program delivery, information management, or program design, because they have or potentially have a strong awareness of what all players in the Strategy are doing, an awareness not to be expected of any of the players themselves. With this broad and comprehensive perspective, they ought to be in a better position to facilitate co-ordination at not only the level of policy, but of program design and delivery as well.

The problem, at root, is that no one has made it clear what co-ordination is in the context of Canada's Drug Strategy, either within or outside of Health Canada, and the Canada's Drug Strategy Secretariat has not been fully accepted as a key player in Canada's Drug Strategy by this department. Until this is rectified, there is little reason to expect significant progress in co-ordinating inter-Branch or inter-departmental programming.

Secretariat officials have taken to describing themselves as the conscience of Canada's Drug Strategy. What they mean by this appears to be that they attempt to keep the federal participants focused on the overall objective of the Strategy and to remind them that each department's efforts are part of a larger initiative whose success depends upon there being a concerted effort towards a common goal. Such a role may not be sufficiently strong to result in improved co-ordination. More is said of the role of the Canada's Drug Strategy Secretariat in the inter-departmental report.

chapter 4
information

SOME BACKGROUND

The Evaluation Framework of 1992 treated information as one of the four mechanisms for enhancing Canada's Drug Strategy programs. This gives it an importance appropriate for a time of fiscal restraint. Government is no longer able to enhance programming primarily by enlarging budgets. Rather, programming will be improved by such measures as improved targeting, co-ordination, and improved development and use of information. Appeal to sound information is essential to policy development, program design, program targeting, and co-ordination. Sound information has always been essential to making rational decisions, but, now, its importance also lies in providing services in the most cost-effective manner possible.

HEALTH CANADA'S INTENTIONS

Health Canada received funds from Canada's Drug Strategy explicitly for information purposes. The programs or organizations that received money specifically targeted for information were:

- Canada's Drug Strategy Secretariat
- National Health Research and Development Program
- Canada's Alcohol and Other Drugs Survey
- Canadian Centre on Substance Abuse

Other programs conducted research and collected information for their own internal purposes, some of directly related to the Drug Strategy, some of which pre-dates the Strategy. For example, the Health Promotion Directorate's public awareness campaign conducted research on out-of-the-mainstream youth to be better able to effectively reach this population. And the Health Protection Branch is very active in collecting data, for example, on psychoactive drug prescriptions, on new forms of street drugs and their effects upon users, and on drug-related crime. The Drug Strategy has enabled them to upgrade their information technologies and automate some of the data collection. This last example of research and data gathering is not

new with Canada's Drug Strategy, but it is integral to it. The Health Protection Branch engaged in these activities before the Strategy began.

ACTUAL INFORMATION-RELATED ACTIVITY:

It is to the credit of Health Canada's role in Canada's Drug Strategy that some of its information-related activities concern the new target populations. The NHRDP funds are entirely for use on extramural research on the same high-risk groups that were chosen by the Health Programs and Services Branch, namely, out-of-the-mainstream youth, women who mis-use drugs and alcohol while pregnant, seniors who mis-use prescription drugs, off-reserve aboriginals, and those who drive while impaired. This indicates sensible planning. Not only are the targets those of the Branch, but they are also targets about whom more research will improve programming. Comparatively little is now known about these high-risk populations, but the research being done by or sponsored by Health Canada should help to inform programming and its development.

NHRDP

CADS

During Phase I, the Health Programs and Services Branch conducted the first National Alcohol and Drug Survey, an extensive survey of Canadians on their alcohol and other drug consumption. This is being repeated during Phase II as the Canadian Alcohol and Drug Survey (CADS), and will include the territories, who were omitted during the first survey. If this survey is regularly conducted, it will be a valuable tool for analysing consumption trends and determining how to improve the effectiveness of substance abuse programming.

CDS Secretariat

The Memorandum to Cabinet noted the requirement for information that would help Canada's Drug Strategy determine its degree of success and accordingly mandated the Secretariat to collect data that would be useful for policy development, program design, and evaluation. In consultation with the Canadian Centre on Substance Abuse and other Strategy partners, the Secretariat has chosen to fund the following projects, each of which should provide information fundamental to the objectives of Canada's Drug Strategy:

1. A project to develop an alcohol and drug epidemiological data base. The Canadian Centre on Substance Abuse is carrying out the project which is designed to improve drug-related epidemiological data and thereby improve policy and program planning at both a national and local level. Also involved are the Secretariat, the Alcohol and Other Drugs Programs Unit, the NHRDP, the RCMP, some provincial representatives, and

some academics. Resulting data should be of use to future evaluation work in this field.

2. A project to develop a model for collecting data that indicate the economic costs of drug-related harms. This project, too, is being carried out by the Canadian Centre on Substance Abuse, and is international in scope. The project is expected to include a series of workshops beginning in the autumn of 1995. Economic harm was among those drug-related harms identified by the evaluation framework as falling under the general harm reduction objective of Canada's Drug Strategy.

3. A project to co-ordinate drug-related research results in Canada and the United States. The Canada's Drug Strategy Secretariat is managing a contract. The aim of this project is to maximize the benefit to Canada of drug-related research done in other countries, most notably the U.S. One element of this project is to determine ways to improve the co-ordination of research efforts within Canada.

The Canada's Drug Strategy Secretariat together with the National Health Research and Development Program engaged in an early consultation process with Canada's Drug Strategy partners to determine the Strategy's data needs. These projects are the result, although they identified additional data needs. However, there has been no comprehensive Strategy-wide data needs assessment or one for Health Canada's contributions. Most data collection is program-specific, and it must be recognized that it is considerable. But what appear to be missing are the links between the information needs of Health Canada, the data and/or information that is actually produced, and, finally, the use of this information for decision-making. To put the point yet more generally, what appears to be missing is a plan that would integrate the production and use of information to the objectives of Canada's Drug Strategy.

The Secretariat attempted, during the first year of Phase II, Phase II to identify measurable objectives for Canada's Drug Strategy in order to attempt to put in place a performance measurement system. Unfortunately, they were unable to reach agreement with the Inter-departmental Committee for Canada's Drug Strategy on which objectives to measure or on how to carry the measurements out.

No plan for information management

This problem is not unique to Health Canada's Drug Strategy programs. The evaluation of the NHRDP demonstrated the systemic difficulties in disseminating and using research results; and the Health Canada business line reviews of 1993-1994 indicated shortcomings in the development and use of information in the department. And, there is currently taking place a government-wide science and technology policy review to improve the government's performance in this area. Phase I of the Strategy did include a data needs assessment. A document was produced (The Psychoactive Substances Information System) but apparently little used. Although it formed the starting point of the consultations mentioned above, Phase II no longer uses this old document nor has replaced it. Without a clear idea of what data are needed, for what, and by whom, the department and the Drug Strategy risks making decisions on the basis of insufficient evidence, or of wasting money producing information that is not needed, that is not used because it is not properly disseminated or properly presented, or by duplicating effort.

There is some recognition of these problems. For example, the Health Promotion Directorate together with the Canadian Centre on Substance Abuse held workshops in 1993 on the usefulness of the National Alcohol and Drugs Survey. Among other things, they learned that the data resulting from the survey were often irrelevant to the needs of program delivery, were inaccessible or difficult to gain access to, were difficult to use except by academic researchers, and were inadequately analyzed for the needs of decision makers. In short, the survey produced good information for academic researchers but was less useful to government. Its successor, the Canada Alcohol and Drug Survey will attempt to improve its usefulness.

Health Canada sees in its future a gradual shift away from direct program delivery towards providing funding, information, expertise and other knowledge products and services. The experiences of Canada's Drug Strategy show a need for improvement in the management of knowledge and information. What is needed is:

- a co-ordinated understanding of what information is needed by Health Canada for developing policy and legislation, for designing and delivering programs;
- a co-ordinated plan for producing this information for the Department, not just on a program by program basis;
- a way to ensure that the results of data collection and analysis are usable by those who make decisions

- a way to facilitate the profitable use of this information by those who make decisions.

There are a number of examples of decision-making processes that appear not to take full advantage of available information. One specific example is the development by the Health Protection Branch of the legislation to replace the Narcotic Control Act and the Food and Drugs Act, Parts III and IV. This legislation, which will affect all partners of Canada's Drug Strategy and all Branches of Health Canada, has not in general been developed in concert with the other Branches of the department or with the Canada's Drug Strategy Secretariat and thereby may not have availed itself of all pertinent information. This is not in any way to pass judgement on the resulting legislation, which remains in draft form, but to comment on the process by which it has been developed over the years. The oft-noted lack of communication between the branches of Health Canada is manifest in the often poor dissemination of information throughout the department.

It is generally unclear how it is that Health Canada uses the enormous amount of data and information available in the substance abuse field. There was little evidence that the Drug Strategy was developed using the data bases maintained by the Health Protection Branch or the survey information from the Health Programs and Services Branch or the information stored at the Canadian Centre on Substance Abuse's clearinghouse. Similarly, little evidence was presented exhibiting how this sort of information is used in designing programs or developing policy at Health Canada.

There exist, however, examples of beneficial information exchange, despite the lack of a departmental information plan. The shared work concerning off-reserve aboriginals brought about a sensible sharing of information between the Branches designing programs for this population. And there are fora for information exchange; the interdepartmental committees that meet to exchange information, and the Canadian Centre on Substance Abuse with its drug information clearinghouse, and the Canada's Drug Strategy Secretariat. Although Health Canada representatives sit on the interdepartmental committees, they do not exist to expedite Health Canada decision-making.

chapter 5
resources

A SUNSETTING INITIATIVE

Canada's Drug Strategy is a sunsetting initiative. However, given that such a large proportion of its funds is to supplement programs previously receiving A-base funds, were it to sunset would not automatically imply the cessation of the programs that fall under it. Again, some of the programs nominally included in Canada's Drug Strategy are fully funded through A-base budgets, although this is not the case at Health Canada. Most, however, are at least partially funded through ongoing funds; very few receive their entire budgets through the Drug Strategy.

In these times of scarce resources, sunsetting initiatives have become a more popular way to fund programs. In theory, establishing sunsetting programs allows the government to respond to special problems without being committed to long-term expenditures. In the case of Canada's Drug Strategy, Phase I, the government was responding to a perceived unusual severity in alcohol and other drug-related problems in Canada. The Strategy was renewed for a second phase on the grounds that the problem persisted, that the balanced approach the Strategy represented was sound, and that it needed to be given a more focused set of targets for maximum effectiveness. Whether the degree of seriousness of Canada's drug problems will decline to the point that it is no longer necessary to inject these special funds cannot be rigorously predicted. However, if the need for sunsetting initiatives remains beyond Phase II, that is, beyond the ten years of this special initiative, the government must consider whether or not Canada's Drug Strategy ought to be a sunsetting initiative, whether it should be cancelled on the grounds that this sort of infusion of funds will not be effective in significantly ameliorating the problem, or whether the initiative should be given A-base funding. Strategy organizers must face the possibility, however, of non-renewal and plan for how it will

deal with the loss of a substantial influx of funds. The loss of supplementary funds could bring about the collapse of the Strategy, especially the intended element of co-ordination. It is crucial to recognize that the Strategy is not entirely dependent upon additional funds. Through the other means of program enhancement, it could continue to exist even with a loss of the sunsetting dollars.

BUDGET CUTS

The cuts to departmental budgets over the past few years have affected some Drug Strategy programs at Health Canada. For an evaluation to be fair, it must take into account the actual funding received by a program. It would be patently unfair to assess a program on the assumption that it received a certain amount of money when it received, for example, only half its allocation.

The issue of budget cuts is complex for Canada's Drug Strategy. Given that many programs receive a combination of A-base and Drug Strategy dollars, it is difficult, perhaps arbitrary to describe the effects of cuts; even to describe a cutback as being to the A-base or to the Drug Strategy portion of the entire program budget becomes arbitrary. The fact of the matter, as far as the effectiveness of some of its programs is concerned, is that some programs had less money to work with than expected. The Strategy was, in some cases, to increase the effectiveness of a program by injecting more money into it. However, if the program's A-base funds are cut, this effectively could nullify any advantages resulting from an infusion of Drug Strategy funds. It is important to assessing program performance, then, to take into account any cuts to program funding, whether it be to the A-base or to a special infusion of funds from a sunsetting program.

"Double Jeopardy"

It is a matter of some controversy how departments manage funding cuts. One question that often arises is whether Strategies are exempt from budget cuts. From one point of view, it does not matter: a cut is a cut, be it from one budget or another. In the end, a program has fewer dollars to work with. However, there is often said to be a special consideration with sunsetting dollars that some departments have come to call "double jeopardy". A Health Canada report on National Strategies from March, 1994, describes it this way:

> Double jeopardy refers to the situation whereby Strategy funds are included in the base upon which this department must effect cuts and yet these funds are treated differently from departmental funds at renewal. Should a sunsetting program

not be renewed, the department's reference levels would be reduced by the full value of the sunsetting program as originally approved, regardless of whether the program had been subject to reduction. The implications of this TBS policy are:

- the inclusion of sunsetting programs in the A-base for the purpose of calculating departmental reductions coupled with a "full payback" policy creates a "double jeopardy situation for those departments which for whatever reasons, target sunsetting programs for reduction.
- to avoid the above situation, departments would be forced to seek the full extent of reductions from non-sunsetting programs, which results in an inordinate burden placed on ongoing programs far beyond the reduction levels intended by the proposed cuts.

In very general terms, the first of the jeopardies appears to be cuts to program budgets, as ordered by the Department of Finance and implemented by the Treasury Board; the second, the loss of the entire original allocation, as defined in the Treasury Board decision, when an initiative sunsets. Thus, at first glance, it would appear that, in a situation where a program has suffered budget cuts, including cuts to resources provided by a Strategy, the non-renewal of a sunsetting program would mean the loss of more than the original allocation, namely, the original allocation together with any resources implicated in a general budget cut. In a case where this occurred, a department would lose more money than was originally allocated to it through a Strategy. Clearly, were this to occur, being the recipient of a sunsetting Strategy would be a liability for a department, and one might predict that departments would come to have very little interest in taking part in sunsetting initiatives.

The question, however, is of the extent of the danger. Treasury Board officials confirmed in interviews that it is the Department of Finance's intention that sunsetting dollars be included in the base from which budget cuts are calculated. However, they also stressed that there has been relief given to departments for cuts to the grants and contributions portions of sunsetting programs. There has not yet been similar relief given for the operating and management dollars that have been cut, but the Board is aware that there is a problem and is trying to rectify it. This is, they stated, a very complex budget issue.

Thus, it would appear that, while double jeopardy is a real problem, it may not be as serious a problem as some would have it because of the relief given on the grants and contributions budgets.

Shifting funds

It can happen that funds originally designated for a Strategy end up being used for other purposes. If Strategy dollars are not maintained as a completely separate budget item (as seems to be the case for Canada's Drug Strategy if the Main Estimates, Part III, are any guide), that is, if Strategy dollars are treated by a department in the same fashion as A-base dollars, then it could easily happen that they are used for other purposes. Canada's Drug Strategy is especially at risk of this happening because so much of its budget goes to supplement previously existing programs. As managers shift A-base dollars from one program area to another in the normal course of events, it can easily happen that Drug Strategy dollars get moved along with them. Aside from the original intentions of the Treasury Board for the use of this money not being met, the result of shifting money from the Drug Strategy to other program areas could be a reduction in the effectiveness of the Strategy. During prolonged periods of shrinking budgets, then, even Strategies whose funds are protected from budget cuts may be vulnerable to a form of "raiding", and thereby vulnerable to reduced effectiveness, both from the loss of Strategy dollars to other program areas and from the loss of A-base dollars from programs that the Strategy supports. The final evaluation study, set for completion in 1997, will attempt to assess whether Canada's Drug Strategy has suffered a loss in effectiveness as a result of budget reductions or transfers of funds to other program areas.

Spending to date

The actual and anticipated spending of Canada's Drug Strategy funds, in so far as the mid-term review was able to determine in concert with Branch representatives, is presented in the following tables. Discrepancies between the original budget figures and actual expenditures represent budget cuts, transfers of Strategy funds to other uses, and lapses. Please note that the figures are in thousands of dollars, are for the entire Branch and are not detailed according to directorate or division or to use, for example, salary, non-salary, grants and contributions, etc. The original budget figures are those contained in the Memorandum to Cabinet, and the actual or anticipated expenditure figures were supplied by the Branches.[3] Further, these figures predate the February, 1995 federal budget and do not include any of its implications.

Health Programs and Services Branch

Year	1992-93	1993-94	1994-95	1995-96	1996-97
Original budget	13,500	18,000	18,000	16,500	16,500
Cuts, lapses transfers	2,026.5	3,243.6	4,173	3,032	2,197
Actual	11,473.5	14,756.4	13,827	13,468	14,303

Medical Services Branch

Year	1992-93	1993-94	1994-95	1995-96	1996-97
Original budget	2,500	2,500	2,500	2,500	2,500
Cuts, lapses, transfers	-	-	-	-	-
Actual	2,500	2,500	2,500	2,500	2,500

Health Protection Branch

Year	1992-93	1993-94	1994-95	1995-96	1996-97
Original budget	170	3,370	3,370	3,370	3,370
Cuts, lapses, transfers	0	1,539	n/a	n/a	n/a
Actual	170	1,831	n/a	n/a	n/a

Possible responses

The framework for evaluating Canada's Drug Strategy referred to

three orders of objectives for the Strategy, one of which was described as mechanisms for enhancing programs. This "third order", as it was called, included improved targeting, co-ordination, information, and resources. Budget supplements were cast as one of four ways to enhance programming. The point of this is that budget supplements are regarded as having no greater importance than the other mechanisms for improving program performance. In general, that one of these mechanisms is diminished should be compensated for by augmenting the others. Thus, the diminution of the budget supplements should, then, be compensated for by yet further improvements to targeting, co-ordination, and information.

The previous chapters, especially that on co-ordination, suggest that there may, indeed, be room for attempting these sorts of compensation. An obvious starting point is co-ordination with regard to funding itself. For example, some Drug Strategy programs lapsed funds during the first two years of Phase II. More creative co-ordination of resources could include a sharing of lapsed funds identifiable as Strategy funds among the different Branches, rather than have them simply lapse.

Cross-strategy connections

A somewhat more adventurous form of resource co-ordination would involve co-ordinating between related Strategies or major initiatives. Alcohol and other drug problems often occur along with other problems that Health Canada is involved in rectifying, among them family violence, AIDS, poor nutrition, mental health problems, problems with the well-being of children, and others. The connections between these problems and the programs that attempt to deal with them are ripe for exploitation to the benefit of all related programs. Further, a determinants of health approach to each of these problem areas will uncover similarities in the determinants that could be dealt with by a single program. More will be said of this in the next chapter.

Future Funding

The federal budget of February, 1995 has made evident the real possibility, perhaps the likelihood, that Canada's Drug Strategy will sunset in 1997. This would, it appears, affect all programs except those offered by the Medical Services Branch whose funds are protected. This possibility together with some of the considerations raised in the following chapter will require the Department and Drug Strategy officials to re-establish the role of Health Canada and the federal government in alcohol and other drug abuse programming.

chapter 6
the environment of canada's drug strategy

The 1992 evaluation framework for Canada's Drug Strategy left open the possibility of reporting on issues beyond the bounds of the framework itself, which for this mid-term review were restricted to the four mechanisms for enhancing programs. A number of significant changes have taken place in the Drug Strategy's "environment" that ought to receive attention from Strategy officials at Health Canada. Some of these concern the policy environment within which the Strategy finds itself, some concern changes in the provinces, and others concern changes to the levels of drug-related harm experienced by Canadians. The reason for providing this information here is not to make judgements about the effectiveness of Canada's Drug Strategy at meeting its harm reduction objectives, but to provide an indication, well before the final evaluation, of situations that demand the attention of Drug Strategy officials at Health Canada.

HEALTH CARE REFORM

Concern over the costs of the health care system and their contribution to federal and provincial deficits has prompted governments to begin to reform the system to reduce its costs. Activities at the federal level include the work of the National Forum on Health, and their contribution to the Federal, Provincial and Territorial Advisory Committee on Population Health, and the work within Health Canada on the issue, conducted by a large network of working groups. The provinces have tackled these issues individually and together through fora such as the Federal-Provincial-Territorial Advisory Committee. Many have begun to change their system of health care delivery, sometimes in ways that affect Canada's Drug Strategy.

Changes in the provinces

Over the past few years, many of the autonomous provincial addictions agencies have been dissolved and their functions assumed by ministries of health. Some representatives of the provincial addictions services regard these transfers as an indication of a declining importance of their work and clientele while others see them as a natural outcome of the view that alcohol and drug issues are

health issues. No matter what the causes of this organizational change, which has affected all provinces and territories but Alberta and Manitoba, and Ontario,[4] it has meant for some discontinuity of the organization of addictions services and some changes in personnel. This has caused some difficulties in communications not only between the federal and provincial governments, but also between provinces. It is simply not always clear who one should contact in a given jurisdiction. This has obvious implications for co-ordination, it being virtually impossible without communications between partners. At the time of the interviews, many, including some Health Canada officials, expressed confusion over who represents certain provinces in the addictions field.

Not only has the transfer of responsibilities for addictions to health departments meant for some communications difficulties, the current reform of the health care system has added some of its own. One element of the reform movement is to devolve some responsibilities and authorities to regions or districts of some provinces in order for health programs to be more responsive to community needs. As authorities are transferred from ministry headquarters to the regions or districts, the power of the provincial headquarters may be reduced. Indeed, some of the provincial officials interviewed expressed the fear that regions might choose not to offer addictions programming at all. Some argued that it is becoming difficult to know who speaks for the province in the addictions field, the Ministry or individual regions or districts. Further, it can be unclear whether there is a single voice speaking for a province that has regionalized its addictions services, whether such a province has a single position on addictions issues. Responsibility for addictions can be distribute across numerous different offices, and it is often unclear to Strategy officials who represents the province on a given addictions issue.

The implication for setting national policies is clear: if the federal government wishes to work with the provinces and territories as partners in setting national policies or in developing national programs, it may be more difficult establishing who are the partners than it was before the amalgamation of addictions services into health departments and before health care reform began. There is not only the matter of who has the authority to set policy, but the very simple problem of knowing whom to contact, knowing who speaks for the province. The Canadian Centre on Substance Abuse has formed a federal-provincial working group on alcohol and other drug policy; this may help to mitigate the problem.

POLICY CHANGE AT HEALTH CANADA

Since the re-organization of government in 1993 which abolished Health and Welfare Canada, Health Canada has worked to establish a new mandate and a broad policy framework for carrying out its new mandate. The vision statement adopted by the Department reads:

> **Health Canada sees a renewed national health system that is based on a health determinants approach to population health and that ensures universal access to appropriate and cost-effective health care.**
>
> **This vision is sustained by national leadership and partnerships on health and the provision of timely, responsive and evidence-based advice and action on health issues.**

This is a general statement that applies to Health Canada's activities in the Drug Strategy as much as it does to any other of its work. The mid-term review would ask what this vision implies for the Strategy and what have Strategy officials done to assimilate this vision into their work? The Canada's Drug Strategy Secretariat has not yet developed a position on this. However, any position that they develop might take some of the following ideas into account.

Determinants of health

A determinant of health is a cause that, usually in concert with other causes, brings about a particular state of health, either of an individual or a population. The state of health brought about may be anywhere on the spectrum of poor to excellent. Determinants are neutral in this regard. What are the particular things that are the causes of particular states of health is an empirical question that can be answered only through empirical research. It is not an ideological question.

Determinants normally work in sets and often determine each other. Often there are "chains of determinants", chains of causes that, as a set, result in a particular state of health. Consequently, one should not refer to THE determinant of health or, in an unqualified sense, to the most important determinant of health. As causes, each member of the chain of determinants is active in bringing about its consequent state of health. A change in the chain of determinants will change the health outcome. Determinants can be either positive or negative, that is, conducive to a positive state of health or to a negative state of health. And both positive and negative determinants can be in the same chain.

Why care about determinants of health?

Because determinants usually work in chains or groups, each member of which may be just as efficacious as any other, interventions designed to improve health status may be rendered ineffective by one member of the chain if it is ignored in the intervention. As a result, a program may be ineffective or less effective, and valuable resources wasted.

A classic example of this brought about the healthy public policy movement and the resulting concern over the determinants of health. The story in brief goes something like this. In the early 1970s, governments were hopeful that disease prevention could be made vastly more effective by changing the health behaviours of individuals. Health promotion, especially in the form of social marketing, came to be seen as an effective way to improve the health of a population, and many such programs were created. However, these programs were not as successful as originally hoped for certain sub-populations, and explorations into why this should be so discovered determinants of health other than individual lifestyle and behaviour, other determinants that to a large extent thwarted the potential of social marketing. Some of these were socio-economic.

The lesson to take from this sort of example is that a government intervention cannot be guaranteed success if it concerns only some determinants in a chain. In the case of lifestyles or health behaviours, while they are determinants of health, they are only part of a chain, and a part relatively close to the health outcome. If one goes "farther up the chain", one will discover what it is that determines lifestyle, and this cause may well affect the degree to which a lifestyles intervention will be effective for a population or various sub-populations. Some of Health Canada's drug strategy programs attempt to work at what are taken to be deeper causes of substance abuse, for example, those programs that attempt to build self-esteem in youth. The basic idea is that the sort of message found in the "Just Say No" programs will not be effective for those with insufficient self-esteem to say no to their peers, that improved self-esteem will help young people deal with this sort of peer pressure or other negative influences.

A determinants approach

A determinants of health approach, then, is an evidence-based approach to designing interventions to improve the health of populations that utilizes information specifically about the full range of determinants of the health status of a population. There are many possible ways of using the determinants of health approach, the

obvious being to select the targets of interventions. However, there is a somewhat more subtle but historically justified use of the determinants as a test for any possible intervention. The test would work in this general way. Of any intervention directed towards any determinant, ask if its effectiveness will be mitigated by determinants higher up in the chain of determinants. If the answer is no, then, all other things being equal, one should proceed with the intervention. However, if the answer is yes, then one can either develop an intervention for this higher determinant, or, if this is inappropriate, determine the resulting cost-effectiveness of the original intervention and decide to proceed or not. The determinants approach can, then, be utilized also as a cost-control device just as much as it can assist in designing effective programs.

Determinants of health and other Strategies

Current thinking about what are the major determinants of health indicates a convergence of determinants for a number of different health conditions that Health Canada deals with, some of them through sunsetting programs. Many of the conditions associated with poor health are found in greater concentration among those with low income, low levels of education, high levels of unemployment, and so on. Thus, some conclude that low income and the other conditions are important determinants of comparatively poor health and are manifest in such unhealthy behaviours as tobacco use, substance abuse, family violence, gambling, poor eating habits, and so on. Details aside, the point is that the determinants of health approach indicates that many different unhealthy behaviours and conditions of ill health can be traced to common causes. This approach would advocate dealing with these different problems as related problems, related through their root causes.

This comes as no real surprise. We have known for a very long time that many programs serve the same client group, that often it is the same people who receive substance abuse services, employment services, family violence services. The determinants of health approach, then, suggests blurring the divisions between some health problems related through common causes and at least giving attention to the ways that different programs approach shared client groups. If nothing else, the determinants of health approach should be cause for greater co-ordination between programs that share clients, if not for radical program re-design (that targets primarily populations rather than problems) and perhaps amalgamation. This applies to multi-departmental sunsetting initiatives as much as it does to individual programs.

DRUG-RELATED HARM TO INDIVIDUALS

Canada's Drug Strategy was introduced in 1987 as a special measure to counter a perceived increase in the severity of substance abuse problems in Canada. The 1992 framework document described a range of harms that the Strategy will attempt to reduce. One of these is premature death. This report will present some mortality data from the years 1987 to 1992, the most recent year for which Statistics Canada data are available. These data do not give reason for optimism and should be of concern to Canada's Drug Strategy officials. However, they are presented primarily as another facet of the Strategy's environment, not as in themselves an indicator of the effectiveness of Canada's Drug Strategy or of Health Canada's role in it.

DRUG OVERDOSE DEATHS IN CANADA, 1987-1992

Drug type	1987	1988	1989	1990	1991	1992
Opiates	56	55	58	82	133	148
Cocaine	59	80	99	65	92	78
Barbiturates	45	34	34	29	30	29
Alcohol	120	116	112	110	155	178
Tranquilizers	27	20	24	23	17	15

Although these Statistics Canada data indicate a slowly reducing incidence of overdose deaths due to barbiturates and benzodiazepine-based tranquilizers, the trends for the opiates, of which heroin is the most common, cocaine, and alcohol give cause for concern. From the time that the Drug Strategy began in 1987 until 1992, heroin deaths have increased by 265%, cocaine deaths have increased by 32%, and deaths due to alcohol poisoning have increased by 48%. (Note that overdoses account for a small percentage of deaths attributable to alcohol abuse; consider, for example, cirrhoses of the liver, impaired driving, and acts of violence.) Whatever the cause of these trends, they show that Canada's Drug Strategy is not yet meeting its goal of

reducing premature deaths caused by these drugs. Its general harm reduction approach should have application to whatever it is that is causing this disturbing trend in drug-related mortality.

Drug deaths in British Columbia

The data just presented do not tell the worst of it because they do not go beyond 1992. However, the province of British Columbia has experienced a severe escalation of drug overdose deaths since 1992. The numbers from 1993 for British Columbia alone, depicted in the table below, are striking:

Drug Type	Deaths
Heroin	298
Cocaine	106
Alcohol	145
Total	549

This situation is clearly extraordinary and it might not be unreasonable to characterize it as a crisis because the number of overdose deaths far exceeds past patterns. At the time that this report was written, Canada's Drug Strategy had made no formal Strategy-wide response to the British Columbia situation. Canada's Drug Strategy regards the province of British Columbia as having sole jurisdiction over this situation, at least until the province indicates that federal involvement is appropriate. Accordingly, the Canada's Drug Strategy Secretariat is taking a position of waiting for a clear signal from the province of British Columbia before it reacts. Preliminary discussions between the province and Health Canada have begun regarding the authorization of physicians to offer methadone maintenance treatment, but as of yet no formal changes have taken place. Health Canada has received no specific request for action and has, therefore, not become involved beyond these preliminary discussions.

The Department has a history of becoming involved with the provinces in crisis situations. The Department has in recent years responded swiftly and effectively to threats posed by tainted mussels and imported grapes as well as to natural disasters such as the

Edmonton tornado. One is immediately led to draw a comparison with the responsiveness of the Emergency Services Division of the Medical Services Branch, along with counterpart organizations in other departments and in other governments, who are charged with the responsibility to take action in the event of certain sorts of emergencies within Canada. One might be excused for expecting there to be an analogous capacity within the drug field where the severity of the harm can be very high.

However, there appears not to exist a plan for the federal government to respond to drug-related emergencies, either on its own or in concert with the provinces. Further, as noted earlier in this report, with the disbanding of the Federal-Provincial Advisory Committee on Alcohol and Other Drug Problems, there no longer exists an organization with a clear responsibility for federal-provincial co-ordination on drug issues, including extraordinary or emergency situations. The situation in British Columbia poses a challenge to the Canada's Drug Strategy partnership, one piece of which is to be federal-provincial, to take joint action in extraordinary situations.

Although they are not confined to Vancouver, most of the overdose deaths have occurred in that city. Therefore, the problem is confined to a relatively small area and could become a good test case for the federal harm reduction approach in the drug field, should the federal government be asked to become more involved. The British Columbia situation is one where a harm reduction approach to substance abuse should have something to offer. It must be noted, however, that Vancouver is not the only city with recently elevated overdose death levels. Toronto and Montreal have also experienced increases, albeit, not to the same extent. Without either a plan or an organizational capacity, it would appear that the federal-provincial partnership has work to do to define what a harm reduction approach to substance abuse involves and implies for federal government and joint federal-provincial action in extraordinary situations.

endnotes

1. Interviews were carried out with 64 representatives of Canada's Drug Strategy at Health Canada. Each Branch was represented as were the Canada's Drug Strategy Secretariat and the regional offices. The interviews were held with program officers, program managers, Directors and Directors General. The two focus groups included twenty Health Canada officials.

   Also interviewed were representatives from each provincial and territorial government's addictions services organization.

2. For the purposes of the inter-departmental evaluation work, two working groups were struck. The Evaluation Working Group is composed of evaluation staff from each department participating in Canada's Drug Strategy together with representatives from the Canada's Drug Strategy Secretariat, the Treasury Board Programs Branch and the Treasury Board's Government Review and Quality Services Division. The Program Working Group was established to advise the evaluators on factual matters and to provide a first point of contact into the Drug Strategy. Its members are program officials from each department.

3. The figures for the Health Protection Branch are incomplete in that they do not reflect whether or not the funds originally directed towards the former Field Operations Directorate for drug analysis were used for that purpose. This review was unable to obtain that information. The expenditure figure assumes that all drug analysis monies were received and used for that purpose. The review was also unable to obtain figures beyond 1993-94 for this Branch.

4. In Ontario, the Addiction Research Foundation still exists as a specialized addictions research agency. However, it now reports through the Ministry of Health.

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